

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2431

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs., 7 mos., 24 days.  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 2 yrs., 7 mos., 24 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2111 Key Blvd., Arlington, Va.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOSEPH W. ALLEN

## 3. (b) Social Security Number

578-03-1162

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Lillian Welch  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1891

8. AGE: Years 55 Months 55 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business \_\_\_\_\_

FATHER 12. Name Ferdinand Allen

13. Birthplace Washington, D. C.

MOTHER 14. Maiden name Annie M. Allen,

15. Birthplace Maryland.

16. Informant Deceased

Address \_\_\_\_\_

17. removal (Burial, cremation, or removal. Which?) Date thereof Feb. 23, 1947  
 (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Washington, D.C.

18. Funeral director W. W. Chambers

Address 3031 M St., N.W., Wash., D.C.

19. Feb 22, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 22 1947 11:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-22-44 to 2-22-47 and that I last saw him alive on 2-22-47

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 3 yrs 4 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

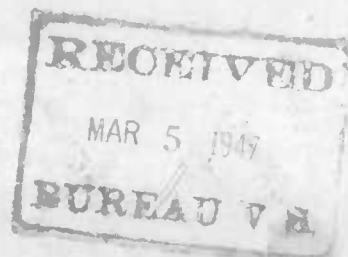
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinucane MD M. D. or other

Address Glenn Dale, Md. Date signed 2-22-47



2-25

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Edman Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Nine years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Edman Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4703 Tanglewood Drive  
(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (a) FULL NAME

Anna May Anderson

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## B. (b) Name of husband or wife

Robert Bernard

## 7. Birth date of

deceased (mo., day, yr.)

Dec. 6th 1888

6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

59

hrs.

min.

## 9. Birthplace

Washington D.C.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## MOTHER

## FATHER

## 12. Name

David H. Beckett

## 13. Birthplace

Washington DC

## 14. Maiden name

Emmel. J. Lousless

## 15. Birthplace

Washington DC

## 16. Informant

Mrs. Catherine Bell

## Address

4703 Tanglewood Drive

## 17. Removal

(Burial, cremation, or removal. Which?)

## Date thereof

Feb 3, 1947  
(month) (day) (year)

## Cemetery or crematory

Washington, D.C.

## Location

## 18. Funeral director

Thomas B. Hanlon

## Address

641- 24th St. NE

## 19. 2/3

(Date rec'd by registrar)

## 19. 47

Amanda Lounney  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Feb 3

## 19

47 at 7 P

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 18 1947 to Feb 3 1947  
and that I last saw him alive on Feb 1 1947

## Immediate cause of death

## DURATION

Cerebral thrombosis

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Leonard Hays  
Address Hyattsville, Md. Date signed 2-3-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8581

STATE OF TEXAS, COUNTY OF DALLAS

STATE OF TEXAS, COUNTY OF DALLAS

STATE OF TEXAS, COUNTY OF DALLAS

4309

RECEIVED

FEB 6 1947

BUREAU V. S.

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16420

## CERTIFICATE OF DEATH

01873

Reg. Dist. No. 2450

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Brentwood  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? House  
 Hospital, institution, or street address where death occurred:  
woods at end of 34th Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Brentwood  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3500 Allison  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Lucien Adrien Archanbault

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Separated

6. (b) Name of husband or wife

Emelia Archanbault

7. Birth date of deceased (mo., day, yr.)

Dec 8, 1906

5. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

40016

hrs. min.

9. Birthplace

Windsor Mills, Canada  
(Town, county, and state)

10. Usual occupation

Joe's Graph Archanbault

11. Industry or business

Canada

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

20. Registrar

21. Signature

22. Date signed

23. Address

24. Date signed

25. Address

26. Date signed

27. Address

28. Date signed

29. Address

## MEDICAL CERTIFICATION

20. DATE OF DEATH

February 1, 1947 at 2:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 19... 19...

and that I last saw him alive on 19...

Immediate cause of death

Asphyxia

Due to

Hanging

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

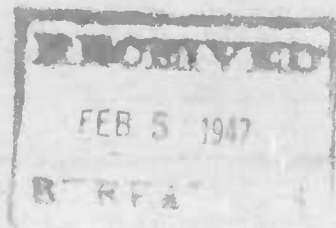
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 2-1-47Where did injury occur? Brentwood, P.S. Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) woods at end of 34th StreetMechanism of Injury Hanging Injured at work? no

Keep up medical examination

23. SIGNATURE

Dresballe M. D. of theAddress 2-1-47



1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-27

## CERTIFICATE OF DEATH

01874

Reg. Dist. No. 2421

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Landover  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death Permanent  
Hospital, institution, or street address where death occurred:  
Carey Home  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)  
State DC County Washington  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 743 - Barnes St. N. E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Isaac A. Bailey

### 3. (b) Social Security Number

4. Sex male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Edith Bailey

7. Birth date of deceased (mo., day, yr.) July 3 - 1886 8.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 60 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mercer County, Pa.  
(Town, county and state)

10. Usual occupation Painter

11. Industry or business Henry Bailey

12. Name Edith Bailey

13. Birthplace Pa. is?

14. Maiden name Emmeline

15. Birthplace Pa.

16. Informant Edith Bailey

Address 743 - Barnes St. N. E. W. C.

17. Removal Feb 18 47  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location Washington, D. C.

18. Funeral director Malvan & Schey Inc.

Address 224 R. St. N. W. D.C.

19. 2-18- 47  
(Date rec'd by registrar)

Registrar H. L. D. Griffith

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 19 47 at 4:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Acute congestive heart failure  
Due to cardiovascular renal disease  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results as above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Deputy Medical Examiner

Address Forestville Md Date signed 2-18-47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 26 1947

BUREAU V B

2-25

2-2420 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83-8

## CERTIFICATE OF DEATH

01875

Reg. Dist. No. 230

1. PLACE OF DEATH: *Geo Co.*  
 County *Berwyn Md*  
 City or town *(If outside city or town limits, write RURAL and give nearest town)*  
 How long in above place of death  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *Md* County *Geo Co*  
 City or town *Berwyn Md*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *8703 50th place*  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

*Lillie Elizabeth Baker*

## 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*  
 6. (b) Name of husband or wife *Wm H. Baker*  
 6. (c) If alive, give age *69* years  
 7. Birth date of deceased (mo., day, yr.) *Sept 3, 1875*  
 8. AGE: Years *71* Months *5* Days *8* If less than one day  
 hrs. min.

9. Birthplace *Md*  
 (Town, county, and state)  
 10. Usual occupation *housewife*  
 11. Industry or business  
 12. Name *George Wilcofen*  
 13. Birthplace *Md.*  
 14. Maiden name *Mary E. McDonald*  
 15. Birthplace *Md.*

16. Informant *Wm H. Baker*  
 Address *Berwyn Md.*  
 17. Burial, cremation, or removal: Which? *Burial* Date thereof *Feb 13, 1947*  
 (month) (day) (year)  
 Cemetery or crematory *St John's*  
*Beltsville Md*  
 Location *F. Gaschi sons*  
 18. Funeral director *Hyattsville Md.*  
 Address  
 19. *Feb 13th* 19 *47*  
 (Date rec'd by registrar) *John D. Smith*  
 Registrar

## MEDICAL CERTIFICATION

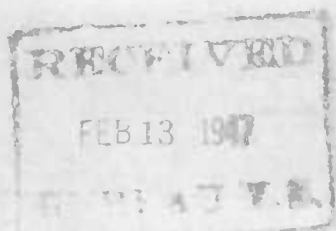
20. DATE OF DEATH *Feb 11, 1947* at *3:10 A* M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *15 JAN* 19 *47* to *11 FEB* 19 *47*  
 and that I last saw her alive on *11 FEB* 19 *47*  
 Immediate cause of death *Cerebral Thrombosis & Embolism*  
 DURATION  
 Due to *Arteriosclerosis* *10 yrs +*  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, pub'c place (where?)  
 Means of injury injured at work?

23. SIGNATURE *W. E. Cheever*  
 Address *Berwyn Md* M. D. or other  
 Date signed *12 FEB 47*



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

## CERTIFICATE OF DEATH

Reg. Dist. No. 232

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Annie M. Ball

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(c) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife John Thomas Ball

7. Birth date of

deceased (mo., day, yr.) April 10 - 1861

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

851013

hrs.

min.

9. Birthplace

Washington, D.C.  
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Charles L. Fizzell

13. Birthplace

Virginia

MOTHER

14. Maiden name

Sarah E. Reagan

15. Birthplace

Washington, D.C.

16. Informant

Mrs. Sarah A. Buck

Address

Upper Marlboro, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

2-26-47  
(month) (day) (year)

Cemetery or crematory

Fairfax

Location

Fortville, Md.

18. Funeral director

Fitch Brothers

Address

Upper Marlboro, Md.

19.

(Date rec'd by registrar)

Feb 26

19

47

Registrar

EdithBall

Registrar

Ball

Registrar

Ball

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1947 at home M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 15 1946 to Feb 23 1947and that I last saw him alive on Feb 23 1947

Immediate cause of death

Bright Lobar Pneumonia DURATION 2 days

Due to

Coronary Heart

Due to

Failure DURATION 2 months

Other conditions

Arteriosclerosis DURATION 10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James E. Farrier

Address

Upper Marlboro, Md.

Date signed

2-26-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
FEB 27 1947  
BUREAU V B

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-0)

## CERTIFICATE OF DEATH

01877

MV 2450  
Reg. Diat. No.

## 1. PLACE OF DEATH:

County Prince Georges  
City or town Rivendale, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 1/4 hrs.  
Hospital, institution, or street address where death occurred:  
Belmont Memorial Hospital  
How long in hospital or institution? 6 1/4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3112 McComas St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war World War II ✓

## 3. (a) FULL NAME

Thomas Whitelaw Barden

## 3. (b) Social Security Number

215-20-2805

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 19258. AGE: Years Months Days If less than one day  
21 4 14 hrs. min.9. Birthplace E. Kent, Va.  
(Town, county and state)10. Usual occupation ex. former truck driver11. Industry or business unmarried lady12. Name Jessie J. Barden13. Birthplace Green County, Va.14. Maiden name Wally Gertrude Holliday15. Birthplace ?, Va.16. Informant Russell Barden (brother)Address 8504 Silver Spring Rd. Silver Spring, Md.17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 2-18-47  
(month) (day) (year)Cemetery or crematory ARLINGTON NATIONALLocation ARLINGTON Co. VIRGINIA.18. Funeral director Edwards & HumphreyAddress SILVER SPRING MARYLAND19. Feb 18 47 James Leroy  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1947 at 7:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION

Hemorrhage and shockDue to Crushed chest and pelvicfracture of the skull

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur College Park P. S. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place, or other \_\_\_\_\_

Medical history \_\_\_\_\_

23. SIGNATURE James Leroy M. D. or otherAddress Forestville Rd. Date signed 2-16-47

RECEIVED

<sup>19</sup>  
FEB ~~IX~~ 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01878

Reg. Dist. No.

1. PLACE OF DEATH Prince George

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Leland Memorial

How long in hospital or institution?

42 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D.C.

County

City or town

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3015 Channing St. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3.(a) FULL NAME

John Thomas Lee Beall.

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife

Margaret Beall

deceased

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

May 1st. 1863

8. AGE:

Years

83

Months

9

Days

17

If less than one day

..... hrs. .... min.

9. Birthplace

Clinton Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Beall

FATHER

12. Name

Beall

13. Birthplace

Maryland

MOTHER

14. Maiden name

Priscilla Fowler.

15. Birthplace

Maryland

16. Informant

Mrs Katherine Unkle.

Address

3015 Channing St. N.E. - D.C.

Burial

17.

(Burial, cremation, or removal, Which?)

Date thereof

Feb 20 1947

(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Suitland, Md.

18. Funeral director

Address

300 - 4th. St. N.E. Wash. D.C.

19.

(Date rec'd by registrar)

Feb 18 1947

Mrs. Jas. Severe

Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 18

1947 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

January 6, 1947

19

to Feb 18 1947

and that I last saw him alive on

Feb 18

1947

Immediate cause of death

Cormary shunt

DURATION

2 months

Due to

arteriosclerotic cardiac disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

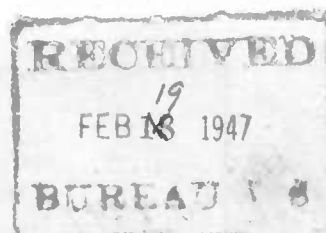
Harry R. Andley M.D.

Address

1201 Act St

Date signed

Feb 18 1947



1-25

2-2450 — 1-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-Q

## CERTIFICATE OF DEATH

Reg. Dist. No.

01879

2432

### 1. PLACE OF DEATH:

County Prince George's  
City or town Hall - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 months  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. # 2  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

William Thomas Beall

### 3. (b) Social Security Number

---

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

61 White Widowed

6.(b) Name of husband or wife Maud Chaney

(Deceased)

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) August 1 - 1885

8. AGE: Years 61 Months 6 Days 20 If less than one day hrs. min.

9. Birthplace Leeland - Md  
(Town, county, and state)

10. Usual occupation Sawyer

11. Industry or business Same

12. Name Charles Beall

13. Birthplace Leeland

14. Maiden name Mary Vermillion

15. Birthplace Upper Marlboro, Md

16. Informant William T. Beall Jr

Address Chaney - Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 24, 1947  
(month) (day) (year)

Cemetery or crematory Greenwood

Location Bladensburg Md

18. Funeral director F. G. Schaefer

Address Syatherville Ind

19. 2/23/47 Amanda Dunning Registrar

2-27-47 Louise H. Peach

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 19 47 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 19 46 to Feb. 21 19 47

and that I last saw him alive on Feb 20 19 47

Immediate cause of death

Constrictive Heart Failure

DURATION

3 months

Due to Cardio - Vascular 2 yrs

Renal Disease

Due to Arteriosclerosis 10 yrs

Other conditions Secondary Anemia 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations none

Autopsy results no Date of op. ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury Injured at work?

23. SIGNATURE James F. Sarracer M. D. or other

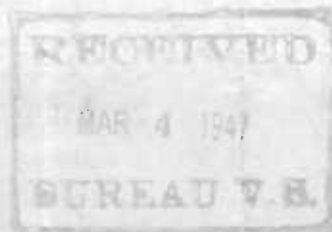
Address Upper Marlboro, Md. Date signed 2-21-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS-415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



2-25

2-2430 - 2-10



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01880

Reg. Dist. No. 2310

### 1. PLACE OF DEATH:

County Prince George's  
City or town Cherry Hill  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Read on arrival  
Hospital, institution, or street address where death occurred:  
Prince George's General Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Camp Springs  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5700 Allentown Road  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

George Merritt Belew

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Effie Ellen Belew

6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 8, 1874

8. AGE: Years 72 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business General Building

12. Name George R. Belew

13. Birthplace Virginia

14. Maiden name May Willie Rice

15. Birthplace Virginia

16. Informant Mrs. Effie Ellen Belew

Address 5709 Allentown Rd

17. Burial Date thereof Feb 16 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel's Cemetery

Location Alexandria, Va.

18. Funeral director Dr. J. Chambers Coon

Address 517 11th St. S.E. D.C.

19. Feb 16 19 47 Amanda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 19 47 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death Coronary occlusion

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Medical Examiner

Address Forestville, Md. Date signed 2-16-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

04570

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF QUALITY

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED  
FEB 18 1947  
BUREAU V. A.

1-55

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

01881

## CERTIFICATE OF DEATH

Reg. Dist. No. 2420

## 1. PLACE OF DEATH:

County Prince Georges

City or town Mountville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Mountville  
(If outside city or town limits, write RURAL and give nearest town)Street No.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Naomi Helen Berry

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Benjamin Berry

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

Feb 9, 1908

## 8. AGE:

Years

38

Months

11

Days

25

If less than one day

hrs.

min.

## 9. Birthplace

Washington D.C.  
(Town, county, and state)

## 10. Usual occupation

Homemaker

## 11. Industry or business

## MOTHER FATHER

## 12. Name

Charles Mercer

## 13. Birthplace

Washington D.C.

## 14. Maiden name

Elizabeth Blount

## 15. Birthplace

Virginia

## 18. Informant

Mary Jackson

## Address

666 - Chillum St NE DC

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Feb. 8, 1947  
(month) (day) (year)

## Cemetery or crematory

Lincoln Memorial

## Location

Suitland Rd

## 18. Funeral director

Malvan &amp; Scher

## Address

4024 - R. St. N.W.

## 19. Feb 5

(Date rec'd by registrar)

19 47

Carrie F. Campbell

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

February 4, 1947, at 11:00 PM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 10... 19...

and that I last saw him alive on 19...

## Immediate cause of death

Sepsis

## DURATION

## Due to

Pneumonia - Lobar

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

Deputy Medical Examiner

## 23. SIGNATURE

James J. Felt

M. D. or other

Address

Inverness Md

Date signed

2-4-47

MARGIN RESERVED FOR BINDING

VS A15

9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 10 1947

BUREAU V. R.

1-35

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

## CERTIFICATE OF DEATH

01883

Reg. Diat. No. 2310

## 1. PLACE OF DEATH:

County Prince George's County  
 City or town Lanham, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 weeks  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's  
 City or town Lanham, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2nd Street  
 (If rural, give LOCATION)  
None

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

KENNETH GRANVILLE BROWN

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) January 25, 1946 1947  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months 1 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)

10. Usual occupation None11. Industry or business None

FATHER 12. Name Granville R. Brown  
 13. Birthplace Maryland

MOTHER 14. Maiden name Rachel Ryon  
 15. Birthplace New York

16. Informant Mr. Granville R. Brown (Father)  
 Address 2nd Street Lanham, Maryland.

17. Burial Date thereof March 1, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Fort Lincoln Cemetery  
 Location Washington, D. C.

18. Funeral director W. W. CHAMBERS CO.  
 Address RIVERDALE, MARYLAND.

19. 2/28 47 Amanda Doney  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1947 at 12:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him/her \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_

asphyxia  
 Due to Smothering in  
mattress of bassinette  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide accident Date of 2-27-47

Where did injury occur? Lanham P. G. Ind  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home  
 Means of injury Smothered in bed clothing.

Deputy Medical Examiner  
 23. SIGNATURE Janner D. Boyd M. I. or other \_\_\_\_\_

Address Forestville Md Date signed 2-27-47

RECEIVED

MAR 4 1947

BUREAU OF

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

## CERTIFICATE OF DEATH

01882 2421  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Prince George'sCity or town Camp Springs  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred:

5504 Allentown Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Camp Springs  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5504 Allentown Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Glenn Garfield Buckler

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

8.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

January 15, 1947

8. AGE:

Years

Months

Days

It less than one day

111

hrs.

min.

9. Birthplace Cheverly, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

James Parran Buckler

13. Birthplace

Maryland

MOTHER

14. Maiden name

Blanche Goldsmith

15. Birthplace

Maryland16. Informant Mrs. Blanche Buckler

Address

5504 Allentown Road

17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof 2-27-47  
(month) (day) (year)

Cemetery or crematory

Bell's Cemetery

Location

Camp Springs P.O. Box

18. Funeral director

James P. Buckler

Address

5504 Allentown Rd. Camp Springs, Md.

19.

2-26-47

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 19 47 at 9:00AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Asphyxia

DURATION

Due to

Smothering in bed clothing

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2/26/47Where did injury occur? Camp Springs P.O. Box Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Smothered in bed clothingDeputy Medical Examiner James P. Buckler

23. SIGNATURE

M. D. or other

Address

Date signed



RECEIVED

MAR 3 1947

BUREAU V.B.

2-25

2-2420 — 2-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01884

## CERTIFICATE OF DEATH

Reg. Dist. No. 2431

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 year, 22 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 1 year, 22 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1710 28th St., S. E.  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

**FRANCIS J. BURNS**

3. (b) Social Security Number  
**577-01-5035**

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ellen P. Burns  
6. (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1096  
8. AGE: Years 41 Months 41 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Providence, Rhode Island  
(Town, county, and state)

10. Usual occupation Statistical Clerk

11. Industry or business \_\_\_\_\_

FATHER 12. Name Patrick J. Burns  
13. Birthplace Massachusetts

MOTHER 14. Maiden name Catherine Cunningham  
15. Birthplace Rhode Island

16. Informant Deceased  
Address \_\_\_\_\_

17. Removal Date thereof 2-2-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory To Wash DC

Location \_\_\_\_\_

18. Funeral director Thomas B. Boulton

Address 641 N. N. E.

19. Feb 2, 1947 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 2 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 9 1946 to FEB. 2 1947  
and that I last saw him alive on FEB 2 1947

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 4 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions G.T. TUBERCULOSIS 4 mos  
TUBERCUL. LARYNGITIS 5 mos  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pincus M.D. M. D. or other \_\_\_\_\_

Address Glenn Dale, Md Date signed 2/2/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 15 1947

BUREAU # 2

2-25

2-2430

— 2-10

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01885

Reg. Dist. No. 2431

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Maryland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 mos., 25 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 933 H. St., N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

SHERMAN W. BYRD

## 3. (b) Social Security Number

579-20-3373

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced  
Single (common-law wife)

6. (b) Name of husband or wife Mrs. Catherine Handback6. (c) If alive, give age 29 years7. Birth date of deceased (mo., day, yr.) Oct. 14, 1908

8. AGE: Years 38 Months 3 Days 17 If less than one day  
 ..... hrs. .... min.

9. Birthplace Phillipsburg, North Carolina  
(Town, county, and state)10. Usual occupation Floor Sander

## 11. Industry or business

12. Name John Byrd13. Birthplace Phillipsburg, North Carolina14. Maiden name Ella Shields15. Birthplace Phillipsburg, North Carolina16. Informant Deceased

Address

17. Removal Date thereof 2/5/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory District morgueLocation Washington, D.C.18. Funeral director Glenn Dale San. - Glenn Dale Md.

Address

19. Feb. 1, 1947 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1947 at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6, 1946 to Feb. 1, 1947  
 and that I last saw him alive on Feb. 1, 1947

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

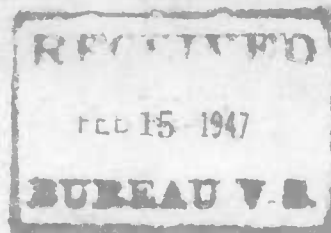
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.Address Glenn Dale, Md. Date signed 2-1-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

2-2430

2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 190

## CERTIFICATE OF DEATH

01886

Reg. Dist. No. 2310

## 1. PLACE OF DEATH:

County... Prince Georges  
City or town... New Port Heights  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?... Transient  
Hospital, institution, or street address where death occurred:  
59th Avenue  
How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Maryland County... Prince Georges  
City or town... Suitland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

## 3. (a) FULL NAME

John Chestnut

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) August 1922

8. AGE: Years 25 Months Days If less than one day hrs. min.

9. Birthplace North Carolina  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business U.S. Govt

12. Name John Chestnut

13. Birthplace North Carolina

14. Maiden name Rachel Parker

15. Birthplace North Carolina

16. Informant John Chestnut

Address New Port Heights

17. Removal Date thereof Feb 9, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Melvin &amp; Schey Funeral Home

Location 424 West Washington St.

18. Funeral director F. Paschis sons

Address Hyattsville Md.

19. 2/9 47 Amanda Downey

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1947 at 11:04 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., 10....., 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

Exposure to cold  
Due to lying out in the open all night

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Accident Date of 2-8-47

Where did injury occur? New Port Heights P.S. Me  
(City or town) (County) (State)

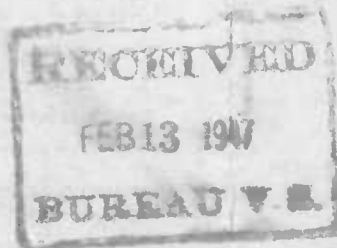
Injured at home, farm, industry, public place (where?) In field

Means of injury Lying in open road? In road at work?

Reported by medical examiner

23. SIGNATURE James P. ... M. D. or other

Address... Forestville Md. Date signed 2/9/47



1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-8

## CERTIFICATE OF DEATH

01887

Reg. Diat. No. 2450

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Riversdale, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yr. 3 mo. 19 days  
 Hospital, institution, or street address where death occurred:  
Deland Memorial Hospital  
 How long in hospital or institution? 3 yr. 3 mo. 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George  
 City or town Mt. Rainier  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4010 - 33rd St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Clayton, Louella May

## 3. (b) Social Security Number

4. Sex F. 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Nov. 21, 1882

8. AGE: Years 64 Months 2 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Iowa  
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

FATHER 12. Name Andrew Augustus Carpenter

13. Birthplace Massouri

MOTHER 14. Maiden name Rebecca Ann Hildreth

15. Birthplace Indiana

16. Informant Hospital Records

Address Riversdale, Md.

17. Burial Feb 10, 1947

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Colman Masonry Co.

18. Funeral director J. G. Galt, Sr.

Address Hyattsville, Md.

19. Feb 9 1947

(Date rec'd by registrar) Registrar J. J. Jones, Sever

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1947 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1946 to Feb 8 1947 and that I last saw him alive on Feb 7 1947

Immediate cause of death Cerebral thrombosis DURATION 3 1/2 yrs.

Due to General arteriosclerosis

Due to \_\_\_\_\_

Other conditions Epilepsy

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE L W Malin MD M. D. or other \_\_\_\_\_

Address Riversdale, Md. Date signed 2-8-47

RECEIVED

FEB 10 1947

BUREAU

1-35

Evidence for the change of MARYLAND STATE DEPARTMENT OF HEALTH  
age is shown on G 112/ 10/15/47

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.

01888

2431

## 1. PLACE OF DEATH:

County Prince Georges  
City or town Glenn Dale, Maryland.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 26 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 26 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 312 I. Street, S. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

GEORGE JACOB COLE

## 3. (b) Social Security Number

577-12-2524

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Separated

6.(b) Name of husband or wife Margaret King Cole

6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) June 1, 1906

8. AGE: Years 41 Months 41 Days 1 If less than one day 27 hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Carolina County, Virginia  
(Town, county, and state)

10. Usual occupation Laborer

## 11. Industry or business

12. Name William Cole

13. Birthplace Carolina County, Virginia

14. Maiden name Kate Robinson

15. Birthplace Carolina County, Virginia

16. Informant Deceased

Address \_\_\_\_\_

17. Removal Date thereof Feb-28, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location to Washington, D.C.

18. Funeral director John T. Rhines & Co

Address 501-3<sup>rd</sup> St. S.W.

19. Feb-28, 1947 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 19 47, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 19 47 to Feb 28 19 47 and that I last saw him alive on Feb 28 19 47

Immediate cause of death Pulmonary Tuberculosis DURATION 3 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results Widespread bilateral infiltration of lungs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Finucane MD M. D. or other

Address Glenn Dale Md Date signed 2-28-47

RECEIVED

MAR 12 1947

BUREAU V B.

2-25

2-2430 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-a

## CERTIFICATE OF DEATH

01889  
Reg. Dist. No. 2310

## 1. PLACE OF DEATH:

County Prince Georges  
City or town Oxon Hill  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 31 days  
Hospital, institution, or street address where death occurred:  
Prince Georges Gen Hosp  
How long in hospital or institution? 31 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Prince Georges  
City or town Oxon Hill MD  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Cosick, William H.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace MD  
(Town, county, and state)10. Usual occupation Retired

## 11. Industry or business

12. Name John Henry Cosick  
13. Birthplace MD  
14. Maiden name Lara Owens  
15. Birthplace MD

16. Informant Annie Cosick  
Address Oxon Hill, MD

17. Burial Burial Date thereof Feb. 21, 1947  
(Burial, cremation, or removal, Which) (month) (day) (year)  
Cemetery or crematory St. Ignatius Cemetery  
Location Prince Georges County, MD

18. Funeral director Mr. W. Chambers Co  
Address 517 11th St S.E. Wash. D.C.

19. 2/18 47 Amenda Dewey  
(Date rec'd by registrar) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1947 at 10:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-15-47 to 2-18 1947  
and that I last saw him alive on 2-18-47 1947

## Immediate cause of death

Cardiac Insufficiency

## DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions

Renal Insufficiency  
Uremia  
(Include pregnancy within 3 months of death)

Major findings of operations

Prostatic Hypertrophy  
Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Stacy W. Hughes M.D.  
Address James George General Hosp Date signed \_\_\_\_\_  
M. D. or other \_\_\_\_\_

RECEIVED

FEB 20 1947

FEB 20 1947

1-35-

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7

## CERTIFICATE OF DEATH

Reg. Dist. No. 2310

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Farmington Heights  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
1004 - 59th Ave  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Farmington Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1004 - 59th Ave  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Rhyllie Harmon

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) March 29, 1944  
8. AGE: Years 2 Months 10 Days 28 If less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation none  
11. Industry or business

FATHER 12. Name Clinton Harmon  
13. Birthplace West of Columbia  
MOTHER 14. Maiden name Emma C Stewart  
15. Birthplace Maryland

16. Informant Clinton Harmon  
Address 1004 - 59th Ave, Farmington Heights

17. Burial, cremation, or removal, Which? Burial Date thereof Feb 28, 1947  
(month) (day) (year)  
Cemetery or crematory Robert Campbell  
Location Farmington House 423 4th St NW

18. Funeral director F. G. Gochis  
Address Bladenburg Md

19. 2/28 19 47 Annette Sawyer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 19 47 at 7:05 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Loxemia  
DUE TO Bronchopneumonia  
DUE TO  
Other conditions Pertussis

(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Cause of injury Injured at work?

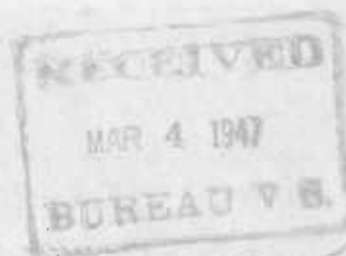
23. SIGNATURE Frederick H. [illegible] M. D. of other  
Address [illegible] Date signed 2-27-47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.





1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. <sup>ne correct age</sup> is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01891

Reg. Dist. No. 2310

## 1. PLACE OF DEATH:

County... Prince Georges County  
 City or town... Landover Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 33 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residences of mother)

State... Maryland County... Pro Geo County  
 City or town... Landover Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Defence Highway  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Curtis C. De Neane

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Florence De Neane

7. Birth date of deceased (mo., day, yr.) Jan 4, 1884- 6.(c) If alive, give age... years

8. AGE: Years 63 Months 1 Days 20 If less than one day hrs. min.

9. Birthplace... Washington D. C.  
 (Town, county, and state)

10. Usual occupation... Retired  
 11. Industry or business Government Printing office

12. Name Joseph De Neane  
 13. Birthplace Pa

14. Maiden name Phebe Cheyney  
 15. Birthplace Pa

16. Informant Florence De Neane  
 Address Landover Maryland

17. Burial Date thereof Feb 26, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Fort Lincoln  
 Location Washington D. C.

18. Funeral director F. Gasch's Sons  
 Address Hyattsville Maryland

19. 2/25 47 Amanda Douney  
 (Date fee'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 24 1947 at 6:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1936 to Feb 24 1947 and that I last saw him alive on Feb 22 1947

Immediate cause of death Acute Coronary Thrombosis

Due to Myocardial Infarction

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address Heathcote Co. Date signed 2/25/47

10574

RECEIVED  
FEB 27 1947  
BUREAU V.B.

1-35-

Evidence for the change of age is  
shown on G 109 3/3/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01892 2310

### 1. PLACE OF DEATH:

County Prince George  
City or town Chester  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 14 years  
Hospital, institution, or street address where death occurred:  
Prince Georges Hosp  
How long in hospital or institution? 49 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince Georges  
City or town Wilda Croft - Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Auburn Ave. & 3rd Ave  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Derry, Mrs. Mary

### 3. (b) Social Security Number

4. Sex F Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Charles W. Derry

7. Birth date of deceased (mo., day, yr.) March 20, 1888 6. (c) If alive, give age 71 years

8. AGE: Years 59 Months 10 Days 160 hrs. min.

9. Birthplace Kansas (Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Cummings, Cherry  
13. Birthplace Kansas

14. Maiden name unknown  
15. Birthplace Kansas

18. Informant Charles W. Derry  
Address Wildercrest Ind.

transportation Date thereof Feb 23, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brownsville  
Location Penna

18. Funeral director F Gasch's sons  
Address Hyattsville Ind.

19. 2/22 19 47 Amanda Doney Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 19 47 6 30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 45 to Feb 22 19 47  
and that I last saw him alive on Feb 21 19 47

Immediate cause of death

Branch of Astoria 2 years

Due to

Due to

Other conditions Chronic deficiency 6 weeks

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. E. T. Co. M. D. or other

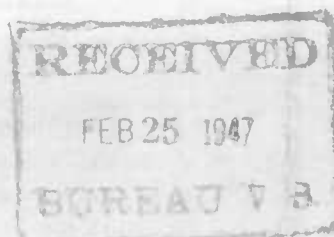
Address Hyattsville Ind. Date signed 2/22/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate exact age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35-

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

## CERTIFICATE OF DEATH

01893

Reg. Dist. No. *2450*

### 1. PLACE OF DEATH:

County *Prince Georges*  
City or town *Farmington Heights*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
*606-60th Ave*  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State *Maryland* County *Prince Georges*  
City or town *Farmington Heights*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *606-60th Ave*  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

*John Odess Hlyson*

### 3. (b) Social Security Number

4. Sex *male* 5. Color or race *colored* 6. (a) Single, married, widowed, or divorced *married*

### 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *August 10,*

8. AGE: Years *43* Months Days If less than one day hrs. min.

9. Birthplace *Maryland*  
(Town, county, and state)

10. Usual occupation *Houseman*

11. Industry or business

12. Name *John L. Hlyson*

13. Birthplace *Maryland*

14. Maiden name *Mary E. Butler*

15. Birthplace *Maryland*

16. Informant *Lillian D. Singletary*

Address *606-60th Ave*

17. Removal *Removal* Date there *Feb 19 1947*  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *1890-194 Church*

Location *Washington DC*

18. Funeral director *Robert H. McGuire*

Address *1820-9th St. NW. Washington, DC.*

19. *Feb 19 1947* James Berry

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 18 1947* at *4:00 PM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death *Tubercula*

Due to *Tubercula pneumonia*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Antopsy results *as above*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE *James H. Berry* M. D. or other

Address *Westville, Va.* Date signed *2-19-47*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6187

UNITED STATES DEPARTMENT OF HEALTH

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RECEIVED  
FEB 20 1947  
BUREAU V.B.

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

1894

Reg. Dist. No. 2431

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 mos., 24 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 5 mos., 24 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 651 G. St., N. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

CHRISTOPHER W. ERVIN

## 3. (b) Social Security Number

242-32-8149

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1924 6. (c) If alive, give age..... years

8. AGE: Years 22 Months 22 Days 1 If less than one day 29 hrs. min.

9. Birthplace Morgantown, North Carolina  
 (Town, county, and state)

10. Usual occupation Bus Boy

11. Industry or business Cafeteria, Pentagon Bldg.

FATHER 12. Name Osia Ervin  
 13. Birthplace Morgantown, North Carolina

MOTHER 14. Maiden name Nina Moore  
 15. Birthplace Morgantown, North Carolina

16. Informant Deceased  
 Address

17. Removal (Burial, cremation, or removal, Which?) Date thereof 2-24-47  
 (month) (day) (year)

Cemetery or crematory To N. Carolina

Location Eugene Ford

18. Funeral director Eugene Ford

Address 1213 4th St. S. W. Wash. D. C.

19. Feb. 24 47 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1947 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 29 1946 to Feb. 24 1947  
 and that I last saw him alive on Feb. 24 1947

Immediate cause of death Pulmonary Tuberculosis DURATION 6 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

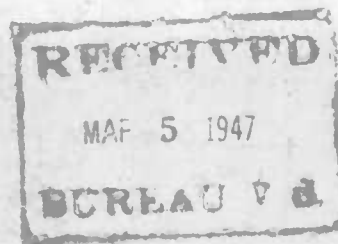
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.

Address Glen Dale, Md. Date signed 2-24-47  
 M. D. or other



2-25

2-2550 - 2-10

## 01895 ④

(13)-a

Reg. Dist. No. .... 232

U.S. Gen. War. Rec. 2-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

01896

## CERTIFICATE OF DEATH

Reg. Dist. No. 2342

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Allentown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 21 years  
 Hospital, institution, or street address where death occurred:  
6625 Allentown Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Allentown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6625 Allentown Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Healy Lily Franklin

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Benjamin Franklin 6. (c) If alive, give age 73 years  
 7. Birth date of deceased (mo., day, yr.) August 4, 1874  
 8. AGE: Years 72 Months Days It less than one day  
 hrs. min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home  
 12. Name Thomas Reed  
 13. Birthplace Unknown  
 14. Maiden name Louise Muelleken  
 15. Birthplace Unknown

16. Informant Benjamin Franklin  
 Address 6625 Allentown Road  
 17. Burial Date thereof Feb 12 - 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill Cemetery  
 Location Forestville Md

18. Funeral director Thos. F. Murray Funeral Home  
 Address 2807 - Nichols Rd. S.E. Wash D.C.  
Feb. 10 1947 Thomas F. Murray  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1947, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19... 19... 19...  
 and that I last saw him alive on 19...

Immediate cause of death Coronary Occlusion  
 Due to Cardiovascular renal disease  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
Deputy Medical Examiner  
 23. SIGNATURE James J. Ford M. D. another  
 Address Forestville Md Date signed 2-9-47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 15 1947

BUREAU V.L.

2-25

2-2340

— 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Evidence for the charge of user addition of*  
*authentic specimen*  
 4709 - 3/6/47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-24

## CERTIFICATE OF DEATH

Reg. Dist. No.

1897

2310

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Chesley  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

Prince Georges HospitalHow long in hospital or institution? 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince GeorgesCity or town Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3405 Otis St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Gertrude A. Franklin

## 3. (b) Social Security Number

4. Sex Female5. Color or race W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 18828. AGE: Years 60 Months 6 Days 4 If less than one day hrs. min.9. Birthplace Clarksville, Georgia  
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name La Foye H. Adams13. Birthplace Georgia14. Maiden name Elizabeth Watson15. Birthplace Georgia16. Informant Daughter Mrs. Bonnie KnightAddress 3405 Otis St. Mt Rainier17. Burial Date thereof Feb. 12 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Clarksville, Georgia18. Funeral director Wm. J. NalleyAddress 3200 - R.R. Ave. Mt. Rainier, Md.19. Feb 12 47 James Devry  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11 February 19 47 at 6 45 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-25-47 to 2-11-47and that I last saw him alive on 2-10-47Immediate cause of death Cerebral Hemorrhage (3) 17 daysLast seen 2-6-47Due to Arteriosclerosis of middleCerebral artery.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Nalley M. D. or otherAddress Mt. Rainier, Md. Date signed 2-11-47

RECEIVED  
FEB 14 1947  
BUREAU V &

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 2450

## 1. PLACE OF DEATH:

County Prince George Co.  
 City or town Wheaton, Pk. 7 Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Mother Jones Rest Home  
(Riggs Rd. Ext

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D. C. County D. C.City or town Washington D. C.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 Franklin St. N. E.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret O. Freeman

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widow

8.(b) Name of husband or wife

Ralph A.

7. Birth date of

deceased (mo., day, yr.)

Oct 19- 1860

8.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8647

hrs.

min.

D. C.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

---Straub

13. Birthplace

Va

MOTHER

14. Maiden name

---Walker

15. Birthplace

Va

18. Informant

Ralph A. Freeman

Address

24 Franklin St. N. E.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereon

Mar 1 1947  
(month) (day) (year)

Cemetery or crematory

St. Mary's Cem.

Location

Washington Dc

18. Funeral director

The S. H. Hines Co.

Address

2901- 14th St. N. W.

19.

(Date rec'd by registrar)

1947

James Sevey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1947 at 4:15 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1943 to 1947  
 and that I last saw him alive on Mar 23 1947

Immediate cause of death

Cardiovascular

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James Sevey  
 Address 35 N. W. 14th St. Date signed Feb 26 1947

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VETERANS AFFAIRS  
OFFICE OF THE ASSISTANT SECRETARY  
WASHINGTON, D. C.

RECEIVED  
FEB 28 1947  
BUREAU V. B.

1-35-

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01902

## CERTIFICATE OF DEATH

Reg. Dist. No. 2431

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 mos., 15 days.  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 7 mos., 15 days.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C.  
County.....  
City or town..... Washington, D. C.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 909 Golden St., S. W.  
(If rural, give LOCATION)  
2. (a) If veteran, name war..... ✓

### 3. (a) FULL NAME

CHARLES GAMBLE

### 3. (b) Social Security Number

4. Sex Male  
5. Color or race Colored  
6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1944.  
6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
2 2 11 hrs. min.

9. Birthplace Washington, D. C.  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name Daniel Gamble  
13. Birthplace Charlotte, North Carolina

MOTHER 14. Maiden name Ida Kennedy  
15. Birthplace Rockhill, North Carolina

16. Informant Nancy Gamble, Aunt  
Address

17. Removal Date thereof Feb. 6, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory  
Location to Washington, D. C.

18. Funeral director Eugene Ford  
Address 1213 4th St SW

19. Feb. 5, 1947 Rowland S. Philips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1947, at 3:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19, 1946, to Feb. 5, 1947, and that I last saw him alive on Feb. 4, 1947.

Immediate cause of death Tuberculous Meningitis  
DURATION 25 da

Due to Pulmonary Tuberculosis (Primary infection) 11 mo.

Due to  
Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results Tuberculous Meningitis, caused metastasizing  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
and mesenteric glands.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinecone M.D.  
M. D. or other

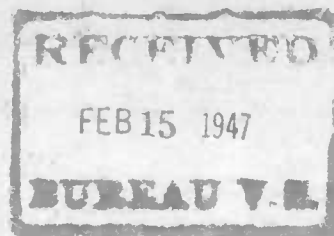
Address Glenn Dale, Md. Date signed Feb. 5, 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1912

## CERTIFICATE OF DEATH

Reg. Dist. No. 23 20

## 1. PLACE OF DEATH:

County..... Pr. George  
 City or town..... Upper Marlboro Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

GANTT  
JANE-E

## 3. (b) Social Security Number

## 4. Sex

7

## 5. Color or race

colored

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

## 8. AGE:

77

Yeare

Months

Days

If less than one day

hrs.

min.

9. Birthplace..... Upper Marlboro Md  
(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

FATHER

## 12. Name

JOS. Colbert

## 13. Birthplace

Md.

MOTHER

## 14. Maiden name

Agatha Croward

## 15. Birthplace

Md.

## 16. Informant

Ada Satawskite

## Address

Upper Marlboro Md

## 17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Feb 20, 1947

(month) (day) (year)

## Cemetery or crematory

1432 You St N W

## Location

Washington D.C.

## 18. Funeral director

W. Ernest Jarvis Co

## Address

1432 You St N W

## 19. (Date rec'd by registrar)

Feb 20 1947

James E. Sawyer Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Pr. Geo.

City or town

Upper Marlboro Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

February 20 1947 5:00 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1946 to Feb 20 1947

and that I last saw him alive on Feb 20 1947

## Immediate cause of death

Cerebral Hemorrhage

## DURATION

3 days

Due to

Nephritis

10 yrs

Due to

Other conditions

Arteriosclerosis

20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

James E. Sawyer

M. D. or other

Address

Upper Marlboro, Md

Date signed 2-20-47

RECEIVED  
FEB 21 1947  
BUREAU V 8

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-P

## CERTIFICATE OF DEATH

01904

Reg. Dist. No. 2431

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Maryland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years, 2 mos., 9 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 2 years, 2 mos., 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 817 5th St., N. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JAMES M. GERIS

## 3. (b) Social Security Number

579-07-5832

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife Augusta Radthe Geris6.(c) If alive, give age 38 years7. Birth date of deceased (mo., day, yr.) June 22, 1898

8. AGE: Years 48 Months 7 Days 9 If less than one day  
 ..... hrs. .... min.

9. Birthplace Friend, Nebraska  
(Town, county, and state)10. Usual occupation Auto-Mechanic

11. Industry or business

FATHER 12. Name Joseph Geris13. Birthplace Chicago, IllinoisMOTHER 14. Maiden name Rose Campbell15. Birthplace Unknown16. Informant Deceased

Address

17. removal Date thereof Feb. 1, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Manassas, Va.18. Funeral director Baker & SonsAddress Manassas, Va.19. Feb. 1 19 47 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 19 47 at 12<sup>10</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Nov. 22 19 44 to Feb. 1 19 47  
 and that I last saw him alive on Feb. 1 19 47.

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.Address Glenn Dale, Md. Date signed 2-1-47



RECEIVED  
FEB 15 1947  
BUREAU V.A.

2-25

2-24-30

2-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01905  
Reg. Dist. No. 2420

### 1. PLACE OF DEATH:

County Prince George's  
City or town Highland Park, Md.  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: 1100 - 70th Place  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) about 25 yrs.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince George's  
City or town Highland Park Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 1100 - 70th Place  
(If rural give LOCATION)  
2(c) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

John Gilbert

### 3. (b) Social Security Number

4. Sex male 5. Color or race negro 6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Francis Gilbert

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) June 1st 1863

8. AGE: Years 83 Months 9 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Laborer

### 11. Industry or business

12. Name George Gilbert

13. Birthplace Md.

14. Maiden name James A. Gilbert

15. Birthplace ?

16. Informant James A. Gilbert

Address 541-24 St. N. E., Wash., D.C.

17. Removal Removal Date thereof Feb. 11-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Washington D.C.

18. Funeral director Allen & Morrow Inc

Address 1326 K St. N.W.

19. Feb. 11 19 47 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 19 47 at 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/10 19 47 to 2/11 19 47  
and that I last saw him alive on 2/10 19 47

Immediate cause of death Acute Congestive Heart Failure DURATION 3 days  
Due to Arteriosclerotic Heart Dis ?

Due to \_\_\_\_\_  
Other conditions Gen. Arteriosclerosis ?

(Include pregnancy within 3 months of death)

### Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert R. Nelson

Address 4112 Grant St. (D.C.) M. D. or other \_\_\_\_\_  
Date signed 2/14/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 13 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01906

Reg. Dist. No.

2310

## 1. PLACE OF DEATH:

County... Prince George's  
 City or town... Poolesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Permanent  
 Hospital, institution, or street address where death occurred:  
 Prince George's General Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... District of Columbia  
 City or town... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1408-18th Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Alexander Gordon

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 1902  
 6. (c) If alive, give age years

8. AGE: Years 44 Month Days It less than one day  
 hrs. min.

9. Birthplace New York City, N.Y.  
 (Town, county, and state)

10. Usual occupation Foreman

11. Industry or business Small Business

12. Name Peter Gordon

13. Birthplace Russia

14. Maiden name Sarah Schwartz

15. Birthplace Russia

16. Informant Maria Gordon

Address 1408-18th Street Washington D.C.

17. (Burial, cremation, or removal, Which?) Burial Date thereof Jan 11, 1947  
 (month) (day) (year)

Cemetery or crematory Resler Cemetery

Location Coatsville Pa

18. Funeral director F Gasche sons

Address Hyattsville Md.

19. Feb 10 1947 James Sevey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1947 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Coronary Occlusion

Due to Coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE James St. John

M.D. or other

Address Hyattsville Md Date signed 2-10-47

RECEIVED

FEB 13 1947

BURFAY

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

01907

243.1

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 mos., 24 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 3 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... D. C.  
 County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 202 Seaton Court, S. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

LUCILLE GROSS

## 3. (b) Social Security Number

577-05-7229

4. Sex..... Female  
 5. Color or race..... Colored  
 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... Jan. 15, 1911  
 6. (c) If alive, give age..... years

8. AGE: Years Months Days It less than one day  
 36 36 1 8  
 .....hrs. ....min.

9. Birthplace..... Washington, D. C.  
 (Town, county, and state)

10. Usual occupation..... Laundry Work

11. Industry or business.....

FATHER 12. Name..... Robert Thomas Gross  
 13. Birthplace..... Maryland

MOTHER 14. Maiden name..... Mary Kathryn Hailey  
 15. Birthplace..... Maryland

16. Informant..... Deceased  
 Address.....

17. Burial..... Date thereof..... 2-24-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... PAYNE'S CEMETERY, INC.  
 Location..... 4640 BENNING ROAD, S.E. WASHINGTON, D.C.

18. Funeral director..... J. J. H. H. E.  
 Address..... 30 H H E

19. Feb. 23, 1947 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 23, 1947, at 5:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 Oct. 28, 1946 to Feb. 23, 1947  
 and that I last saw him alive on Feb. 23, 1947

Immediate cause of death..... Pulmonary Tuberculosis  
 DURATION 9 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

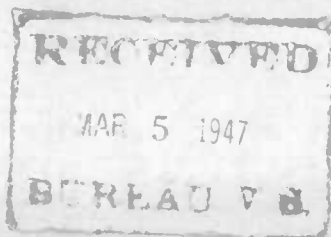
23. SIGNATURE..... Daniel Leo Pinucane M.D.

Address..... Glenn Dale, Md. Date signed 2-23-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 876

## CERTIFICATE OF DEATH

Reg. Dist. No. 2310

## 1. PLACE OF DEATH:

County Prince George  
 City or town Chesley md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 51 days  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? 51 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md. County Pr. George city  
 City or town Mt. Rainier  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3100 Varnum St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Guillet Mrs. Laura

## 3. (b) Social Security Number

4. Sex ♀ 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Mr. John Du Bois Guillet

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1866

8. AGE: Years 80 Months 2 Days 19 If less than one day hrs. min.

9. Birthplace Pa  
 (Town, county, and state)

10. Usual occupation at home

## 11. Industry or business

12. Name William Marshall

13. Birthplace Pa

14. Maiden name Catherine Miller

15. Birthplace Pa

16. Informant Mrs R.P. Bowman

Address Mt Rainier Md

17. transformation Date thereof Feb 17, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Peace

Location Akron Ohio

18. Funeral director F. Busch's sons

Address Hyattsville Md

19. 2/17/47 Amanda Downey  
 (Date rec'd by registrar) 1947 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1947 at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 1947 to Feb 16 1947

and that I last saw her alive on Feb 15 1947

Immediate cause of death Infectious Polyneuritis  
(Guillain-Barre Syndrome) DURATION 51 days

Due to

Due to

Due to

Other conditions Inanition + Dehydration

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

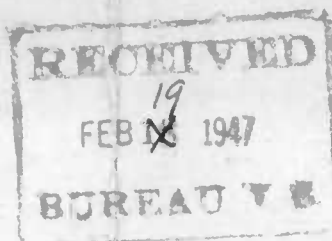
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Samuel J N Sugar MD M. D. or other

Address Mt. Rainier, Md. Date signed 16 Feb '47



1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01909

2431

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 mos., 25 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 4 mos., 25 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4350 Eads St., N. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

WILLIAM HENRY HARRIS

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Maria Curtis  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept. 12, 1869  
 8. AGE: Years 77 Months 77 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace St. Mary, Maryland  
 (Town, county, and state)  
 10. Usual occupation Watchman, (Retired)  
 11. Industry or business Sewer Department  
 12. Name Joseph Harris  
 13. Birthplace Maryland  
 14. Maiden name Jane Warren  
 15. Birthplace Maryland

16. Informant Deceased  
 Address \_\_\_\_\_

17. removal Date thereof Feb. 23, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_  
 Location Washington D.C.

18. Funeral director Alexander S. Pope  
 Address 315 - 15<sup>th</sup> St. SE, Washington, D.C.

19. Feb. 23, 47 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 22 1947, at 8:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 26 1946 to FEB. 22 1947  
 and that I last saw him alive on Feb 22 1947

Immediate cause of death PULMONARY TUBERCULOSIS

DURATION  
18 mos

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinocchio M.D.

Address Glenn Dale, Md Date signed 2-22-47

RECEIVED

MAR 5 1947

B' R. H. 8

2-25

2-2430 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12 - Approx  
Send Pleasant

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

Reg. Dist. No. 01918 20

## 1. PLACE OF DEATH:

County Prince George'sCity or town Pitcher  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Pitcher  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME June Harrison (2nd. Twin)

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Feb 7, 19478. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 3 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Pitcher  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name June Harrison13. Birthplace MD14. Maiden name Hattie Harper15. Birthplace MD16. Informant Mr. Hattie HarrisonAddress Pitcher17. Burial Date thereof 2 10 47  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory LacksonsLocation Forestville Md18. Funeral director Pitcher BrosAddress Upper Marlboro Md19. Feb 10 47 Registrar A. C. Smith  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1947 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Prematurity

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE Respectfully medical Examiner

M. D. or other \_\_\_\_\_

Address Forestville Md Date signed 2-10-47

RECEIVED  
FEB 11 1947  
BUREAU V A

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

1911

2320

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Ritchie  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Ritchie  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Harrison

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife \_\_\_\_\_

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) February 7, 19478. AGE: Years \_\_\_\_\_ Months 0 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Ritchie, Md  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER 12. Name Leroy Harrison13. Birthplace Maryland14. Maiden name Hattie Harper15. Birthplace Maryland16. Informant Mrs. Hattie HarrisonAddress Ritchie, Md17. Burial Date thereof 2 10 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory JacksonsLocation Forestville Md18. Funeral director Ritchie BrosAddress Upper Marlboro Md19. 10 47 Registrar Paul Smith  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1947 at 6:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Prematurity

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ - Injured at work? \_\_\_\_\_

Keep up medical & home23. SIGNATURE James J. [unclear] M.D. or other \_\_\_\_\_Address Forestville Md Date signed 2-9-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.



RECEIVED

FEB 11 1947

H. READ V.B.

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

Reg. Dist. No. 01912 2431

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Glenn Dale, Maryland.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 months, 24 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 5 months, 24 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1103 O. Street, N. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war One month in Navy - 1943

### 3. (a) FULL NAME

HATCHER JAMES

### 3. (b) Social Security Number

578-22-8322

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Jan. 8, 1925.

8. AGE:	Years	Months	Days	It less than one day
	<u>22</u>	<u>22</u>	<u>1</u>	<u>10</u> hrs. _____ min.

9. Birthplace Sanford, North Carolina  
(town, county, and state)

10. Usual occupation Messenger

11. Industry or business Munitions Building

12. Name Jesse Hatcher

13. Birthplace North Carolina

14. Maiden name Gladys Barnes

15. Birthplace North Carolina

16. Informant Deceased.

Address \_\_\_\_\_

17. Removal Date thereof 2/18/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Washington D.C.

18. Funeral director W. Ernest Jarvis Co.

Address 1422 24th St. N.W. Wash. D.C.

19. Feb 18, 1947 Registrar Rowland S. Philip  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/47 19 47 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/23/46 19 46 to 2/18/47 19 47  
and that I last saw him alive on 2/18/47 19 47

Immediate cause of death Pulmonary Tuberculosis  
Complicated with effusion  
DURATION 10 mo  
10 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Mans of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinucane M.D. M. D. or other

Address Glenn Dale, Md. Date signed Feb 18, 1947

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 25 1947  
BUREAU V B.

2-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01913

Reg. Dist. No.

2342

## 1. PLACE OF DEATH:

County..... Prince George's  
 City or town..... Silver Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 37 years  
 Hospital, institution, or street address where death occurred:  
5025 Branch Ave  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Prince George's  
 City or town..... Silver Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5025 Branch Ave., S.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Frank Decker Hazleton

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife..... Luella H. Hazleton6. (c) If alive, give age..... 65 years7. Birth date of deceased (mo., day, yr.)..... June 21, 18828. AGE: Years 64 Months Days If less than one day hrs. min.9. Birthplace..... New York  
(Town, county, and state)10. Usual occupation..... Auto service and gas station operator

11. Industry or business

12. Name..... Edward P. Hazleton13. Birthplace..... New York14. Maiden name..... Henrietta Decker15. Birthplace..... New York16. Informant..... Mrs. Luella HazletonAddress..... 5025 Branch Ave., Silver Hill17. Burial (Burial, cremation, or removal, Which?) Date thereof.....  
(month) (day) (year)Cemetery or crematory..... Cedar HillLocation..... Suitland, Md.18. Funeral director..... Thos. F. MurrayAddress..... 2007- Nichols Ave. S.E.19. Feb. 27 47 Frank Decker  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 27 19 47 at 2:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....  
and that I last saw him..... alive on..... 19.....Immediate cause of death..... Hemorrhage and shock DURATIONDue to..... Gun shot wound through the Head

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Suicide Date of..... 2/27/47Where did injury occur?..... Silver Hill P. G. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?)..... HomeManner of injury..... Shot self through the head

Deputy Medical Examiner

23. SIGNATURE..... Thos. F. Murray M.D. or otherAddress..... Thos. F. Murray Date signed..... 2/27/47

RECEIVED  
MAR 5 1947  
BUREAU V A

2-25

2-2340-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age if age is shown on is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change  
of age is shown on  
4-18-36/47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 102

## CERTIFICATE OF DEATH

01914

Reg. Dist. No. 2300

## 1. PLACE OF DEATH:

County Prince Georges  
City or town Murkbk  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Prince Georges  
City or town Murkbk  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Higgins

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced widow  
6. (b) Name of husband or wife Thomas Higgins  
7. Birth date of deceased (mo., day, yr.) Aug 9, 1863 6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 84 Months 83 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Prince Georges  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden name Milly Franklin

15. Birthplace Md.

16. Informant Bessie Stewart

Address Murkbk Md.

17. Burial Date thereof Feb 28 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Supers chapel

Location Murkbk Md.

18. Funeral director Henry S Washington & Sons

Address 467 N St. N.W.

19. February 17<sup>th</sup> 1947 John D Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 19 47 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16 19 47, to February 16 19 47

and that I last saw h. alive on February 16 19 47

Immediate cause of death Lobar pneumonia,  
Left upper lobe

Due to Chronic bronchitis DURATION 1 week

Due to

Other conditions Chronic myocarditis 10 years

Senility

(Include pregnancy within 6 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE John Stephens, M.D. M. D. or other

Laurel, Maryland Date signed 2/16/47

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19  
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BUREAU 78

1-35-



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

## CERTIFICATE OF DEATH

01915

Reg. Diat. No. 2450

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Riversdale  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
6625-47th Place  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's  
 City or town Riversdale  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6625-47th Place  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

Jean Louise Hoffman

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 19448. AGE: Years 2 Months Days It less than one day hrs. min.9. Birthplace Washington D.C.  
(Town, county, and state)  
Stone

10. Usual occupation

11. Industry or business

12. Name Alex E. Hoffman13. Birthplace Penn14. Maiden name Miss June Low15. Birthplace Colorado16. Informant Alex E. HoffmanAddress Riversdale, Md17. (Burial, cremation, or removal. Which?) Burial Date thereof Feb 15 1947  
(month) (day) (year)Cemetery or crematory Arlington CemeteryLocation Arlington Virginia18. Funeral director F. G. Gandy SonsAddress Wyalapville Ind19. (Date rec'd by registrar) Feb 15 1947 Registrar James Sevey

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1947 at 2:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1947 to 1947and that I last saw him alive on 1947

Immediate cause of death

Shock

DURATION

Due to hypertension, burn of theentire body

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2-14-47Where did injury occur? Riversdale P. 5 h. 27  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury In house that caught on fire at work23. SIGNATURE Frederick M. D. G. Gandy

M. D. G. Gandy

Address Frederick Md Date signed 2-14-47

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1-55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

180

## CERTIFICATE OF DEATH

01916

2450

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Riverdale  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yearsHospital, institution, or street address where death occurred:  
6625-47th Place

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Riverdale  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6625-47 Place  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Sandra Hoffman

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) March 31, 1943

6. (c) If alive, give age .....

8. AGE: Years 3 Months ..... Days ..... It less than one day ..... hrs. .... min.9. Birthplace Washington DC  
(Town, county, and state)10. Usual occupation None

11. Industry or business .....

12. Name Alva E. Hoffman13. Birthplace Penn14. Maiden name Mary Jane Low15. Birthplace Colorado16. Informant Alva E. HoffmanAddress Riverdale, Md17. Burial Date thereof Feb 17, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington CemeteryLocation Arlington, Virginia18. Funeral director F. Gasth SonsAddress Hydelsville Ind19. 71115 47 James Severy  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1947 at 2:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death ShockDue to myocardial infarction of the entire body

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

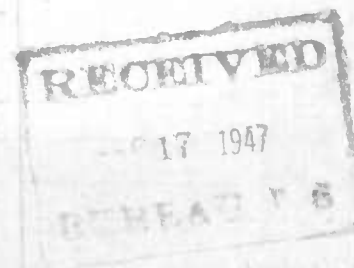
Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-14-47Where did injury occur? Riverdale P. G. Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury In house that caught fireReport to medical officer Yes23. SIGNATURE James Severy M. D. or otherAddress Forestville Md Date signed 2-14-47



1-55-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

## CERTIFICATE OF DEATH

01917

Reg. Dist. No. 2322

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Upper Marlboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Upper Marlboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Anna Halden

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife John P. Halden  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept 3, 1864  
 8. AGE: Years 82 Months 5 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace St Louis Missouri  
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name William Eckhardt13. Birthplace Germany14. Maiden name Bertha Mulge15. Birthplace Germany16. Informant Mrs Stella H. EmmenbowerAddress Upper Marlboro, Md.17. Burial Date thereof 3-21-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary'sLocation St. Louis, Missouri18. Funeral director Fitchie BrosAddress Upper Marlboro, Md.19. Feb 20 1947 Registrar Paul Smith

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1947 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Acute congestive heart failureDue to Cardiovascular renal disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Deputy medical examiner James J. Ford

23. SIGNATURE \_\_\_\_\_ M.D. or other

Address Freshville, Md. Date signed 2-19-47

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1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01918

Reg. Dist. No. 2431

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 mos., 8 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 10 mos., 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1626 Corcoran St., N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

CHARLES W. HOLMES

## 3. (b) Social Security Number

578-16-2515

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Separated  
 6. (b) Name of husband or wife Margaret Gaywood Holmes  
 6. (c) If alive, give age 31 years  
 7. Birth date of deceased (mo., day, yr.) December 13, 1907  
 8. AGE: Years 39 Months 39 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation Porter  
 11. Industry or business \_\_\_\_\_  
 12. Name Charles E. Holmes  
 13. Birthplace \_\_\_\_\_  
 14. Maiden name Lillian Adams  
 15. Birthplace Danville, Virginia

16. Informant Deceased  
 Address \_\_\_\_\_  
 17. Removal Date thereof 2/20/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory \_\_\_\_\_  
 Location Washington D.C.  
 18. Funeral director Eugene Ford  
 Address 12130 4th St. S.W.  
 19. Feb 19, 1947 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1947, 6:15 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APR. 10, 1946 to Feb. 19, 1947  
 and that I last saw him alive on Feb. 19, 1947  
 Immediate cause of death Pulmonary Tuberculosis  
 DURATION 19 yrs.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Daniel Lee Pinucane MD.  
 M. D. or other \_\_\_\_\_  
 Address Glenn Dale, Md. Date signed 2-19-47



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FEB 25 1947

BUREAU V B.

2-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-20

## CERTIFICATE OF DEATH

01919

Reg. Dist. No. 2310

## 1. PLACE OF DEATH:

County PRINCE GEORGE  
 City or town CHEVERLY  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 YEARS  
 Hospital, institution, or street address where death occurred:  
PRINCE GEORGE'S GEN. HOSP.  
 How long in hospital or institution? 36 HRS.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County PRINCE GEORGE  
 City or town HYATTSVILLE  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4913-40th PLACE  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Charlotte Antoinette Hoop

## 3. (b) Social Security Number

4. Sex FEMALE 5. Color or race W 6.(a) Single, married, widowed, or divorced WIDOW

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) NOV. 8-1872.  
 6.(c) If alive, give age..... years

8. AGE: Years 74 Months 2 Days 29 If less than one day  
 ..... hrs. .... min.

9. Birthplace OHIO  
 (Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name JOHN HOOP

13. Birthplace OHIO

14. Maiden name CHARLOTTE WENTLING

15. Birthplace NEW JERSEY

16. Informant SON - RALPH HOOP

Address 4913-40th Pl. HYATTSVILLE-MD

17. Quiesced Date thereof Feb. 8, 1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory First Lincoln Cemetery

Location Prince George County, Md.

18. Funeral director W. W. Chambers Co.

Address 5901 Cleveland Ave. Rix, Md.

19. 2/7 47 Amanda Downey

(Date rec'd by registrar) 19..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 5 1947, at 10<sup>30</sup>P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 ..... 19....., to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death.....

Cardiac decompensation unknown

terminal bronchopneumonia 3 days

Due to Cardio-vascular renal unknown

disease

Due to.....

Other conditions Sanguine 8 tons unknown

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

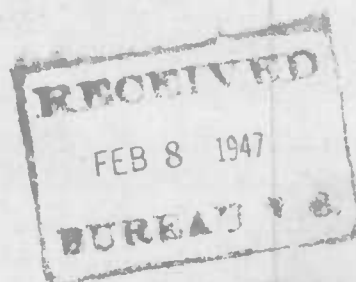
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Gossage, M.D.

Mt. Rainier, Md. M. D. or other

Address..... Date signed 2-6-47



1-35-

MARYLAND

## CERTIFICATE OF DEATH

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS1. PLACE OF DEATH  
County of PRINCE GEORGE'S  
Township of \_\_\_\_\_  
or  
Borough of \_\_\_\_\_  
or  
City of BRANDYWINE (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)Registration  
District No. \_\_\_\_\_Primary Registration  
District No. \_\_\_\_\_File No. 240Registered No. 2400(If death occurred in a  
Hospital or Institution  
give its NAME instead  
of street and number.)2. FULL NAME CHARLES RUSSELL HYDE

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED  
OR DIVORCED (write the word) married5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of ARCHIE GOLDSMITH HYDE6. DATE OF BIRTH (month, day, and year) DEC 16, 18957. AGE Years Months Days IF LESS than  
51 1 28 1 day.....hrs.  
or.....min.

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer).  
(c) Name of employerFARMER9. BIRTHPLACE (city or town) Brandywine  
(State or country) Maryland10. NAME OF FATHER James Albert Hyde11. BIRTHPLACE OF FATHER (city or town) Cedarville, Maryland  
(State or country)12. NAME OF MOTHER Lula Richards13. BIRTHPLACE OF MOTHER (city or town) Cedarville, Maryland  
(State or country)14. Informant Mrs. Mabel Baker, sister  
(Address) Brandywine, Md.15. Filed 2-12, 19 47 F. H. Billingsley  
REGISTRAR

11-3184

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 11 1947  
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased from,  
October, 1946, to February, 1947  
that I last saw him alive on December, 1946  
and that death occurred, on the date stated above, at 4 P. m.  
The CAUSE OF DEATH\* was as follows:Cardiovascular collapse  
due to Chronic bronchitis  
\*pulmonary congestion with  
stasis (duration) about 20 yrs. mos. ds.CONTRIBUTORY (SECONDARY) Possible phthisis  
pulmonary (duration) 18-20 yrs. mos. ds.18. Where was disease contracted Cedarville, Md.  
If not at place of death?Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? none(Signed) Alfred R. Lapeen M. D.  
Feb 11, 19 47 (Address) Agassco, Md.\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state  
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL. (See reverse side for additional space.)19. PLACE OF BURIAL, CREMATION OR  
REMOVAL Horsehead, Md.

DATE OF BURIAL

20. UNDERTAKER Stone BrothersADDRESS upper Marlboro  
Maryland

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer, Farm laborer, Laborer—Coal mine* etc. Women at home who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever write *None*.

**Statement of cause of death.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term of

the same diseases. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup") *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis* of lungs, meninges, peritonaeum, etc., carcinoma, Sarcoma, etc., of ..... (name origin: "Cancer" is less definite: avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitia nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example. *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicaemia" "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—Probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

Space for additional information by physician

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 334

## CERTIFICATE OF DEATH

Reg. Dist. No. 2420

01921

1. PLACE OF DEATH: Prince Georges  
County.....  
City or town..... Fairmount Heights  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 yrs.  
Hospital, institution, or street address where death occurred:  
5702 L St.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Prince Georges  
City or town..... Fairmount Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5702 L St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME Pearl Brooks James

3.(b) Social Security Number

4. Sex Female 5. Color or race Negro 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Philip William James  
6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) March 9, 1904  
8. AGE: Years 42 Months 11 Days If less than one day  
.....hrs. ....min.

9. Birthplace Washington, D.C.  
(Town, county, and state)

10. Usual occupation Wife

11. Industry or business

12. Name William F. Jones

13. Birthplace Greaspoint, Md.

14. Maiden name Nellie Duckett

15. Birthplace Washington, D.C.

16. Informant Mrs. Nellie James (mother)

Address 519 - F St. N.E. Wash. D.C.

17. Removal Date thereof Feb. 10 - 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director Maluan & Schrey Inc.

Address 424 - R St N.W.  
Feb. 10 19 47 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 19 47 at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19 45 to Feb. 19 47

and that I last saw her alive on Feb. 8 19 47

Immediate cause of death Heart Failure

DURATION

Due to Hypertensive Heart Disease Unknown

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Philip Robinson, M.D.  
M. D. or other

Address 1001 Eastern Ave. N.E. Date signed 2/10/47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 13 1947

BUREAU V R

1-30-



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82-2

## CERTIFICATE OF DEATH

Reg. Dist. No.

2420

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Smithland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4358 Spring St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Geo.City or town Smithland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4358 Spring St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MARCUS NICHOLAS LABEL

## 3. (b) Social Security Number

176-09-4604

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Amy Kadel

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 25, 1874

8. AGE:

Years

Months

Days

If less than one day

72

hrs.

min.

9. Birthplace

Butler Co Penna  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Feb. 12

19 47

Carrie F. Campbell

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 19 47, at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 19 46 to Feb. 12 19 47and that I last saw him alive on Feb. 8 19 47

Immediate cause of death

Cerebral Hemorrhage

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. W. Tribadene M.D.Address 3112 4th Ave S.E. Wash. D.C. Date signed 2-12-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 13 1947

BUREAU V B.

1-33-

21 Feb

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age of birth date shown on evidence for addition of birth date shown on film 8, 109-3/19/47-B.

is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of birth date shown on film 8, 109-3/19/47-B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 526

## CERTIFICATE OF DEATH

Reg. Dist. No.

01924

2420

### 1. PLACE OF DEATH:

County Prince Georges Hospital  
City or town Cheverly Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 40 years  
Hospital, institution, or street address where death occurred:  
Prince Georges Hosp.  
1912 1000s  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Prince Georges  
City or town Seat Pleasant  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5979 Rollins Dr.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

George J. Klotz

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lena Klotz

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1875

8. AGE: Years 71 Months Days If less than one day hrs. min.

9. Birthplace Was. Lingdon D.C.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name George J. Klotz

13. Birthplace Was. D.C.

14. Maiden name Martha Ann Arvin

15. Birthplace Was. D.C.

16. Informant Wife - Lena Klotz

Address 5979 Rollins Ar. Seat Pleasant

17. Burial Date thereof March 3 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington National Cem.

Location Shutland Rd. Md.

18. Funeral director Deal Funeral Home

Address 4812 Ga ave NW

19. Feb 28 47 Carrie J. Campbell  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 28 February 47 19 47 at 4 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 (19 46) to Feb 27 (19 47)

and that I last saw him alive on February 27 (19 47)

Immediate cause of death anemia

Due to Carcinoma of bladder

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Brainer

M. D. or other

Address Capital Hotel, Md.

Date signed 2/27/47

### DURATION

8 days

6 months

RECEIVED  
MAR 3 1947  
BUREAU V.S.

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

## CERTIFICATE OF DEATH

01925

Reg. Dist. No. 2310

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Alexandria  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Weeks arrival  
Hospital, institution, or street address where death occurred:  
Prince Georges General Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Villa Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5614-Randolph  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Milton C. Knox

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, or divorced married  
6.(b) Name of husband or wife Sophia Knox  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) August 1, 1907  
8. AGE: Years 39 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wisconsin  
(Town, county, and state)  
10. Usual occupation Engineer  
11. Industry or business Advice Incorporated  
12. Name Perry Knox  
13. Birthplace California  
14. Maiden name Bertha Ruckstron  
15. Birthplace Sweden

16. Informant Mr. Sophia Knox  
Address Villa Heights, Md  
17. Burial Date thereof Feb 6, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Virginia  
18. Funeral director Basch's Sons  
Address Hyattsville, Md  
19. 2/5 1947 Amanda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1947 at 6:51 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_  
Coronary occlusion  
Due to Coronary sclerosis  
Due to Cardiovascular renal disease  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results See above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE Joseph Medical Examiner  
Address Frederick, Md Date signed 2-5-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

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BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01926

Reg. Dist. No. 2431

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1833 7th St., N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

MINNIE B. LEAKS

## 3.(b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Arthur Leaks  
 6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1922  
 8. AGE: Years 24 Months 24 Days 1 27 27 hrs. \_\_\_\_\_ min.

9. Birthplace Winston Salem, North Carolina  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

FATHER 12. Name John Moore  
 13. Birthplace North Carolina

MOTHER 14. Maiden name Lucy Bell  
 15. Birthplace North Carolina

16. Informant Deceased  
 Address \_\_\_\_\_

17. Removal Date thereof Feb. 4, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory to Washington, D.C.  
 Location \_\_\_\_\_

18. Funeral director W. Frank Garmis Co.  
 Address 1432 7th St. N. W. Wash. D.C.

19. Feb. 3, 1947 Rowland S. Philips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1947 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 21, 1947 to Feb. 3, 1947 and that I last saw him alive on Feb. 3, 1947

Immediate cause of death Pulmonary Tuberculosis DURATION 3 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

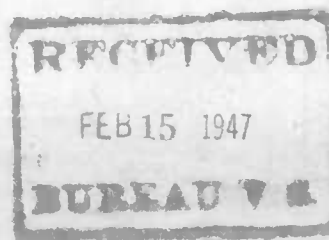
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Mans of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinicane M.D. M. D. or other

Address Glenn Dale, Md. Date signed Feb 3/47





2-25

2-2430 ——— 2-10

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

## CERTIFICATE OF DEATH

Reg. Dist. No. 2310

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Glen Dale  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year  
 Hospital, institution or street address where death occurred:  
Lanham - Severn Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George's  
 City or town Glen Dale  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Lanham - Severn Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Clayton Lewis

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

8.(b) Name of husband or wife Ella LewisB.(c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) August 4, 18998. AGE: Years 47 Months 6 Days 2 If less than one day  
hrs. min.B. Birthplace Georgia  
(Town, county, and state)10. Usual occupation machinist11. Industry or business U. S. Navy12. Name unknown13. Birthplace Georgia14. Maiden name Clayton15. Birthplace Georgia16. Informant Ella LewisAddress Glen Dale, Md17. Burial Date thereof Feb. 10 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington Va18. Funeral director L. G. G. JonesAddress Hyattsville, Md19. 2/8 47 Amanda Deunoy  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1947 at 4 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19... to 19...  
and that I last saw him... alive on 19...

Immediate cause of death

ShockDue to immense burn of the entire body

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2-6-47Where did injury occur? Glen Dale (City or town) Pr. Geo. (County) Md (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury house that burned down23. SIGNATURE James J. Jorg (If D. or other)Address Frederick Md Date signed 2-7-47

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 15 1947

BUREAU V. S.

2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

## CERTIFICATE OF DEATH

01928

Reg. Dist. No. 2431

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Glenn Dale, Maryland.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 years, 9 months, 28 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 2 years, 9 months, 28 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 740 Rock Creek Church Road, N.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

ELVA WOOD LICKLITER

### 3. (b) Social Security Number

217-01-6366

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced divorced

6.(b) Name of husband or wife Harry Theodore Lickliter  
6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1918

8. AGE: Years 28 Months 5 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bealton, Virginia  
(Town, county, and state)

10. Usual occupation Sales Clerk

### 11. Industry or business

FATHER 12. Name Herbert P. Wood  
13. Birthplace Virginia

MOTHER 14. Maiden name Ruby L. Hanback  
15. Birthplace Bealton, Virginia

16. Informant Deceased  
Address \_\_\_\_\_

17. removal Date thereof Feb. 17, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Removal to Washington  
Location W W Chambers Co

18. Funeral director W W Chambers Co  
Address Washington

19. Feb. 16, 1947 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1947 at 11:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1944 to Feb. 16, 1947  
and that I last saw him alive on Feb. 16, 1947

Immediate cause of death Pulmonary Tuberculosis DURATION 5 yrs 2 mo.  
(Fatal hemorrhage of lungs)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

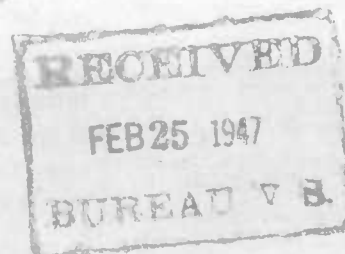
23. SIGNATURE Daniel Leo Pinucane M.D. M. D. or other \_\_\_\_\_

Address Glenn Dale, Md Date signed Feb. 16, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55

## CERTIFICATE OF DEATH

01929

Reg. Dist. No. 2451

## 1. PLACE OF DEATH:

County Prince George's Co.  
 City or town Hyattsville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prs Geo Co.  
 City or town Hyattsville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4312 - Kennedy St  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ida Cornilla Linthicum

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife John W. Linthicum  
 6.(c) If alive, give age 83 years  
 7. Birth date of deceased (mo., day, yr.) March 10, 1866

8. AGE: Years 80 Months 4 Days 5 If less than one day  
 hrs. min.

9. Birthplace Maryland  
 (Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

MOTHER FATHER  
 12. Name James Turner  
 13. Birthplace Washington D.C.  
 14. Maiden name Catherine Bell  
 15. Birthplace Maryland

18. Informant John W. Linthicum  
 Address Hyattsville Md.

17. Burial Date thereof Feb 3, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Stevens CemeteryLocation Hyattsville Md.18. Funeral director W. H. DavisAddress Hyattsville Md

19. Feb 30 19 47 Wm Jas. Severe  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1, 1947 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2, 1934 to Feb 1, 1947and that I last saw her alive on Jan 31, 1947

Immediate cause of death

Carcinoma of Breast

DURATION

5 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

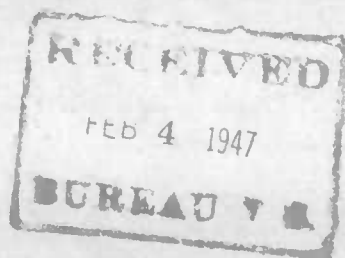
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Davis M. D. or otherAddress Hyattsville Md Date signed 2-1-47



1-25

2-2450- 1-10



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

01930

## CERTIFICATE OF DEATH

Reg. Diat. No. 2451

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Riverdale  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 1/2 Hours  
Hospital, institution, or street address where death occurred:  
Eugene Ieland Memorial Hospital  
How long in hospital or institution? 7 1/2 Hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
City or town Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3210 Perry Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Baby Girl Lowe

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife -

6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) February 24, 1947

8. AGE: Years Months Days If less than one day  
7 hrs. 33 min.

9. Birthplace Riverdale, Maryland  
(Town, county, and state)

10. Usual occupation -

11. Industry or business -

12. Name John F. Haley

13. Birthplace Middleport, New York

14. Maiden name Shirley Mae Lowe

15. Birthplace Niagara Falls, New York

16. Informant Miss Shirley Mae Lowe

Address 3210 Perry Street, Mt. Rainier, Md.

17. Burial Date thereof Feb 25, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenwood

Location Bladensburg Md

18. Funeral director F. G. G. G. G.

Address Hyattsville Md

19. Feb 25, 47 Mrs. J. J. Severe  
(Date rec'd by Registrar) (Signature of Registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 19 47, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 24 19 47, to - 19 -

and that I last saw him - alive on - 19 -

Immediate cause of death Prematurity

Due to -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE S. W. Malin

M. D. or other -

Address Riverdale Md Date signed 2/24/1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 28 1947

BUREAU V.S.

1-25

2-2450 — 1-10

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B-2

01931

## CERTIFICATE OF DEATH

Reg. Diat. No. 2420

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Camp Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
6204 Allentown Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Camp Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6204 Allentown Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Wilford Earl Lusby

## 3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Caroline M. Kim Lusby  
 7. Birth date of deceased (mo., day, yr.) June 5, 1882 8.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 64 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Camp Spring, Md.  
 (Town, county, and state)  
 10. Usual occupation Plumber

11. Industry or business  
 12. Name Richard Thomas Lusby  
 13. Birthplace London, England  
 14. Maiden name Eliza Jane Allen  
 15. Birthplace Camp Spring, Md.

16. Informant Mrs. Caroline M. Kim Lusby  
 Address 5809 - Reservoir Street, Chevy Chase, Md.  
 17. Burial Date thereof 2-6-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill  
 Location Smithfield, Md.

18. Funeral director W. W. Chambers & Co.  
 Address 517 11<sup>th</sup> St. S.E.

19. Feb. 8 1947 Carrie F. Campbell  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1947 at 5<sup>00</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_.

Immediate cause of death Acute congestive heart failure  
Cardiogenic pulmonary disease  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

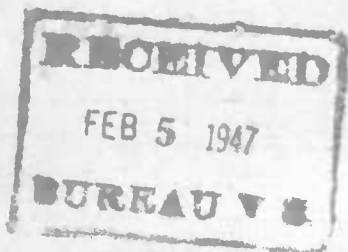
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James J. Forestalls M. D. or other \_\_\_\_\_  
 Address Forestalls, Md. Date signed 2-9-47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (770)

## CERTIFICATE OF DEATH

Reg. Dist. No. 01932 2450

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Mt. Rainier  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town Mt. Rainier  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4203 - Kaywood Drive  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ALTA MAE MADDEN

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Ira P. Madden

7. Birth date of deceased (mo., day, yr.)

Jan 11, 1890

B. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

57

hrs.

min.

9. Birthplace

Milnor, North Dakota

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

12. Name

Shelby Smith

13. Birthplace

Paris, Illinois

14. Maiden name

Elizabeth Bishop

15. Birthplace

Unknown

16. Informant

Ira P. Madden

Address 4203 - Kaywood Drive

17. Cremation Date thereof Feb. 13, 1947  
 (Burial, cremation, or anatomical disposal) (month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation Bladensburg Rd. & D. C. line18. Funeral director Wm. J. MalleyAddress 3200 - R.R. Ave. Mt. Rainier, Md.19. Feb 12 1947 J. J. Sevey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1947 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 14 1946 to Feb 10 1947and that I last saw her alive on Feb 10 1947

Immediate cause of death

Carcinoma of Ovary

DURATION

1 yr

Due to

Due to

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations Carcinoma of Ovary  
with metastasis Date of op. 13 May 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Samuel J. N. Sugar M.D. or otherAddress 4300 Kaywood Dr. Mt. Rainier, Md. Date signed Feb 10, 1947

Married  
Mrs. James  
James James  
James James

James James  
Mrs. James  
James James

ALTA MAE MADDEN

James James  
Mrs. James  
James James

James James  
Mrs. James  
James James

James James  
Mrs. James  
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Mrs. James  
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James James  
Mrs. James  
James James

James James  
Mrs. James  
James James

James James  
Mrs. James  
James James

RECEIVED  
FEB 14 1947  
BERKELEY

1-35



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

01933

## CERTIFICATE OF DEATH

Reg. Dist. No. 2451

## 1. PLACE OF DEATH:

County Prince Georges

City or town Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3306 - Otis Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jane Tompkins Manderschied

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

B. (b) Name of husband or wife

John H. Manderschied

7. Birth date of deceased (mo., day, yr.)

Sept. 28, 1866

B. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

80

4

28

hrs.

min.

8. Birthplace

Highland New York  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

James Tompkins

13. Birthplace

New York

MOTHER

14. Maiden name

Abeline Adams

15. Birthplace

?

18. Informant

Klara Manderschied

Address

3306 - Otis St. Mt. Rainier

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

March 1 - 1947  
(month) (day) (year)

Cemetery or crematory

St. Lincolns Cemetery

Location

Bladensburg Rd. &amp; D.C. Line

18. Funeral director

Wm. H. Nalley

Address

3200 - R.R. Ave. Mt. Rainier, Md.

19. Feb. 28, 1947

(Date rec'd by registrar)

1947

Mrs. Jas. Severely  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

February 26, 1947, at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN. 21, 1947, to FEB. 26, 1947

and that I last saw him alive on FEB. 26, 1947

Immediate cause of death

Generalized CARCINOMATOSIS

DURATION

4 mos

Due to Primary in intestines sigmoid colon

Duration: eight months

Due to

Other conditions MYOCARDITIS AND ASTHMA UNKNOWN

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

D. J. Grayman M.D.

M. D. or other

Address 4118-30th St. Mt. Rainier Date signed 2/27/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

James Thompson  
Age 58  
Date of Death

James Thompson  
Age 58

James Thompson

James Thompson

Age 58

James Thompson

James Thompson

RECEIVED

James Thompson

BUREAU

1-25-47

## STATE OF MARYLAND—CERTIFICATE OF DEATH

01934

## 1. PLACE OF DEATH

County Prince George'sVillage or City Capitol HeightsRegistration Dist. No. 2425No. 6100 Kingston Rd. St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. 5 mos. \_\_\_\_\_ ds. How long in U.S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## 2. FULL NAME

Rachel Ann Virginia Mason

U. S. Veteran, specify WAR \_\_\_\_\_

(a) Residence: No. 6100 Kingston Rd.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

If nonresident give city or town and State \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

female

## 4. COLOR OR RACE

white

## 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

married6a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofDavid Henry Mason

## 6. DATE OF BIRTH (month, day, end year)

July 28, 1864

## 7. AGE

81 Years

## Months

13

## Days

82

## If LESS than

1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

## OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.Housewife9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.None10. Data deceased last worked at  
this occupation (month and  
year)Apr 194411. Total time (years)  
spent in this  
occupation

## 12. BIRTHPLACE (city or town)

Frederick County  
Va.

(State or country)

## FATHER

## 13. NAME

Johnson Clark

## 14. BIRTHPLACE (city or town)

Frederick County  
Va.

(State or country)

## MOTHER

## 15. MAIDEN NAME

Larrah Leroux

## 16. BIRTHPLACE (city or town)

Wheeling  
West Va.

(State or country)

## 17. INFORMANT

Mr. David Henry Mason

(Address)

6100 Kingston Rd, Capitol Hgts, Md.

## 18. BURIAL, CREMATION, OR REMOVAL

Place Capitol HeightsDate Feb 27, 1947

## 19. UNDERTAKER

James J. Jones

(Address)

303 S. Johnson St. W. Va.

## 20. FILED

Feb. 27, 1947Carrie F. Campbell

Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

February  
(Month)27  
(Day)1947  
(Year)

## 22.

I HEREBY CERTIFY That I attended deceased from

Sept 15, 1946, to Feb 27, 1947I last saw him alive on February 27, 1947; death is saidto have occurred on the date stated above, at 2:50 P.m.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:carcinoma of sigmoid  
with metastases.

Date of onset

2 1/2 years

Other Contributory Causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so specify \_\_\_\_\_

(Signed)

William Brannon M. D.(Address) Capitol Heights, Md.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

Reg. Dist. No.

01935

24-1

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 12 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 1 month, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1115 9th St., N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

WILLIE M<sup>C</sup> DANIELS

## 3. (b) Social Security Number

249-07-1440

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Lucille McDaniels  
 6. (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) March 15, 1910  
 8. AGE: Years 36 Months 11 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Marmosa, Florida  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

FATHER 12. Name Willie McDaniels13. Birthplace Marmosa, FloridaMOTHER 14. Maiden name Hannah Williams15. Birthplace Marmosa, Florida16. Informant Deceased

Address \_\_\_\_\_

17. Removal Date thereof 3/1/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory District - morgueLocation Washington D.C.18. Funeral director John H. Henry Grant-SgtAddress Glenn Dale San, Glenn Dale, Md.19. Feb 23, 47 Rowland & Phillips

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 23, 1947 at 6:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN. 10 1947 to FEB 23 47and that I last saw him alive on FEB. 23 47Immediate cause of death PULMONARY TUBERCULOSIS

DURATION

9 mos

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

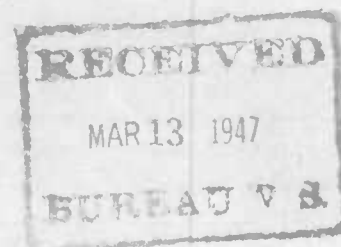
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Pinucane MDAddress Glenn Dale, Md Date signed 2-23-47



2-25-

2-2430 - 2-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01936

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Prince George  
City or town Mount Rainier  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George  
City or town Mount Rainier  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2301- Queens Chapel Rd  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

John W. Mc Devitt

### 3. (b) Social Security Number

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Minnie V Mc Devitt  
7. Birth date of deceased (mo., day, yr.) June 15 1876  
6. (c) If alive, give age years

8. AGE: Years 70 Months Days If less than one day hrs. min.

9. Birthplace Frederick Md  
(Town, county, and state)

10. Usual occupation Printer

11. Industry or business Ransdall Inc

12. Name unknown

13. Birthplace

14. Maiden name unknown

15. Birthplace

16. Informant R C Chamberlin

Address 810 R I Lane NE Wash DC

17. Removal Date thereof Feb 9 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director S H Hines Co

Address 2901-14 St NW

19. Feb 9 1947 Janus Severy Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

2D. DATE OF DEATH February 9 19 47 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to present and that I last saw him alive on Friday 2/7/47 19 47

Immediate cause of death Arteriosclerotic heart disease  
and coronary occlusion - & middle aged

Due to Heart attack attack at 43 years 3-4 yrs  
Due to with occlusion

Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Chas W Holobom M.D.  
Address 508 Indiana St NW Date signed 2/9/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

FEB 10 1947

BUREAU 78

1-35



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

01937

## CERTIFICATE OF DEATH

Reg. Dist. No.

2451

## 1. PLACE OF DEATH:

County Prince Georges

City or town: Forest Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

5300 Gallatin

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town: Forest Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5300 Gallatin Street

(If rural, give LOCATION)

2(a) If veteran, name Spanish American Soldier I

## 3. (a) FULL NAME

James McGlinchey

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

April 3, 1870

## 8. AGE:

76

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

New York City, N.Y.

(Town, county, and state)

## 10. Usual occupation

Retired Soldier

## 11. Industry or business

U.S. Army

## MOTHER

## FATHER

## 12. Name

Cornelius McGlinchey

## 13. Birthplace

Unknown

## 14. Maiden name

Mary McGlinchey

## 15. Birthplace

Unknown

## 16. Informant

Mrs. Eva Deller

## Address

5300 Gallatin Street

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

2/11/47

(month) (day) (year)

## Cemetery or crematory

U.S. Soldiers Home

## Location

Washington, D.C.

## 18. Funeral director

W.W. Chambers

## Address

Riadale - Md.

## 19. (Date rec'd by registrar)

Feb 10, 1947 Mrs. J. J. Severe

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1947 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 10... 19...

and that I last saw him alive on 19...

## Immediate cause of death

Congestive heart failure  
Cardiovascular  
renal disease

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

Keep at medical chamber

## 23. SIGNATURE

James T. Ford

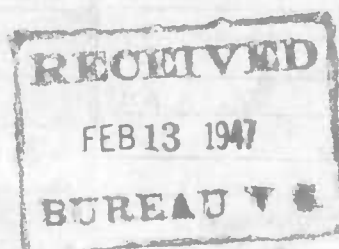
M. D. or other

Address Forest Hills Md Date signed 2-8-47

MARGIN RESERVED FOR BINDING

YS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-25

2-2450

1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 2391

01938

2391

## 1. PLACE OF DEATH

County... Laurel Md

City or town... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yearsHospital, institution, or street address where death occurred: 635 - 8th Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne ArundelCity or town... Laurel (If outside city or town limits, write RURAL and give nearest town)Street No... 635 - 8th

(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3.(a) FULL NAME

John L McPhie

## 3.(b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Annie McPhie6.(c) If alive, give age 88 years

## 7. Birth date of deceased (mo., day, yr.)

Nov 16 - 1864

## 8. AGE:

Years 82 Months 3 Days 11 If less than one day

## 9. Birthplace

Canada (Town, county, and state)

## 10. Usual occupation

Retired Engineer

## 11. Industry or business

Murdock McPhie

## 12. Name

Edinburgh Scotland

## 13. Birthplace

Margaret McPhie

## 14. Maiden name

John Scotia Canada

## 15. Birthplace

Annie McPhie

## 16. Informant

Laurel Md

## Address

Burial

## 17. (Burial, cremation, or removal, which?)

Date thereof Feb. 13/1947 (month) (day) (year)

## Cemetery or crematory

Cedar Hill

## Location

Hubbington Rd. @The D.C. White Co.

## 18. Funeral director

Laurel Md.

## Address

2 - 1319. 47 Cor E. Wachter

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

2 - 10 - 47 19... at 10:30 M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 - 2 - 46 19... to 2 - 10 19... 47and that I last saw him alive on 2/16 19...Immediate cause of death Carcinoma LarynxCentral OvaryDue to adren. Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. J. WachterAddress Laurel Md.Date signed Feb 13/47

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

FEB 18 1947

BUREAU V.A.

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2-2390-2-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 191-20

## CERTIFICATE OF DEATH

01939

Reg. Dist. No. 2451

1. PLACE OF DEATH  
County Pro Geo Co  
City or town Rivendale Ind.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD. County Pro Geo Co.  
City or town 5302 - Taylor Rd  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Rivendale Ind  
(If rural, give LOCATION)  
2.(a) if veteran, name war

3. (a) FULL NAME Mary L. Miller

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband or wife John F. Miller  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) Feb 24, 1877-

8. AGE: Years 69 Months Days It less than one day hrs. min.

9. Birthplace Ra.  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business Thomas Carter

12. Name Thomas Carter

13. Birthplace Ra

14. Maiden name Bryant

15. Birthplace Ra

16. Informant Mrs Eva Ashby

Address 810-7 St S.W. Wash D.C.

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof Feb 25, 1947  
(month) (day) (year)

Cemetery or crematory St Lincoln

Location Washington D.C. Colman Manor

18. Funeral director F. Pasche Sons

Address Nyattsville Ind.

19. Feb 23 1947 Mrs. Jas. Severe Registrar  
(Date rec'd by registrar) (Signature)

### MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 21, 1947 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to 2-21 1947  
and that I last saw him alive on 2-21 1947

Immediate cause of death

Arteriosclerosis

Due to hypertension

Due to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Occurred at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE J. W. C. / Secy

Address Hyattsville Ind.

Date signed 2-22-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 26 1947  
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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

01940

Reg. Dist. No. 243.1

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 1 month, 8 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution?..... 1 month, 8 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 53 I. Street, N. E., Apt. 3  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

H. ALLEN MOSS, JR.

### 3. (b) Social Security Number

579-05-3709

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1914

8. AGE: Years 32 Months 32 Days 4 If less than one day hrs. min.

9. Birthplace Chapel Hill, North Carolina  
(Town, county, and state)

10. Usual occupation Tailor and Presser

### 11. Industry or business

FATHER 12. Name Allen H. Moss, Sr.,

13. Birthplace Chapel Hill, North Carolina

MOTHER 14. Maiden name --- Holmes

15. Birthplace Chapel Hill, North Carolina

16. Informant Deceased

Address

17. Removal Burial, cremation, or removal. Which? Date thereof 2/4/47  
(month) (day) (year)

Cemetery or crematory Washington D.C.

Location 387 S. H. 92 E

18. Funeral director 387 S. H. 92 E

Address 387 S. H. 92 E

19. Feb. 3, 1947 Rowland S. Phillips Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1947, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 24, 1946, to Feb. 3, 1947

and that I last saw him alive on Feb. 3, 1947

Immediate cause of death Pulmonary Tuberculosis DURATION 5 mo.

Due to Tuberculosis Laryngitis DURATION 2 mo.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pincone MD

Address Glenn Dale, Md. Date signed 2/3/47

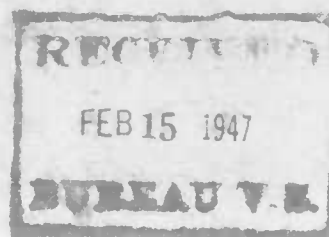
MARGIN RESERVED FOR BINDING

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VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01941

Reg. Dist. No. 2420

1. PLACE OF DEATH:  
County..... Prince George  
City or town..... Capitol Hgts., Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 20 years  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland..... County..... Prince George  
City or town..... Capitol Heights, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 434-57th Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Mary Jane Nairn

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed  
George William  
6. (b) Name of husband or wife  
8. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.) November 24, 1858  
8. AGE: Years 88 Months Days If less than one day  
..... hrs. .... min.

9. Birthplace..... Dover, Delaware  
(Town, county, and state)  
10. Usual occupation..... Housewife  
11. Industry or business  
12. Name John White  
13. Birthplace Unknown  
Osborn  
14. Maiden name  
15. Birthplace Dover, Delaware

16. Informant John W. Nairn  
Address 434-57th Ave.,  
Burial Date thereof 2-4-47  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Arlington Natl. C.  
Location Arlington Va.  
16. Funeral director W. W. Chambers Co.  
Address 517 11th St. S.E.  
19. Feb. 1, 1947 Carrie F. Campbell  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1947 at 4:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1946 to Feb. 1, 1947 and that I last saw him alive on Jan. 31, 1947.

Immediate cause of death: Coroner's report of stomach & temporary imbalances of liver etc.  
DURATION 5 months  
Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE: J. W. Chambers Co. 35 My Ave.  
Address: 35 My Ave. Date signed Feb. 1/47

RECEIVED

FEB 3 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 190

01942

## CERTIFICATE OF DEATH

Reg. Dist. No. 2310

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Fairmont Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Transient  
 Hospital, institution, or street address where death occurred:  
6300 Shepp Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Fairmont Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 701-60th Place  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Nette Munnally

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Separated  
 6.(b) Name of husband or wife Herbert Munnally  
 6.(c) If alive, give age. years  
 7. Birth date of deceased (mo., day, yr.) December 13, 1893

8. AGE: Years 53 Months 2 Days 12 It less than one day hrs. min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER 12. Name Rae Young  
 13. Birthplace Washington  
 14. Maiden name Washington  
 15. Birthplace Washington

16. Informant Hennetta Erwin  
 Address 1412-6th Street NW, Washington

17. removal Date thereof Jan 26, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington Funeral Co  
 Location 467-7th St NW Washington DC

18. Funeral director F. Garcia's sons  
 Address 2247 Atlantic Rd

19. 2/26 1947 Amanda Durey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1947 at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Exposure to cold

Due to sitting out all night in the cold

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-25-47

Where did injury occur Fairmont Heights P.S. Md  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) 6300 Shepp Rd

Means of injury set out in cold all night Injured at work?

Signature James J. Ford M. D. or other

Address Overbrook Ws Date signed 2-25-47

RECEIVED

FEB 27 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B3a

## CERTIFICATE OF DEATH

01943

Reg. Dist. No. 2342

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Alburtown Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 85 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? none

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Washington 20 DC  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6651 Temple Hill Road  
 (If rural, give LOCATION)  
 2(a) If veteran, name war no

## 3. (a) FULL NAME

Amelia Ann Cursler

## 3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed  
 B. (b) Name of husband or wife Chas. Henry Cursler  
 (Deceased) 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 9 1857  
 8. AGE: Years 89 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Montgomery Co. Md.  
 (Town, county, and state)

10. Usual occupation Housework at home.

11. Industry or business at home.

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Roger Cursler

Address 6651 Temple Hill Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 3 1947  
 (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Bertonsville, Md.

18. Funeral director Thomas F. Murray

Address 2007 Nichols Ave. S.E. Wash. 20 DC

19. Feb 3 47 (Date rec'd by registrar) Thomas F. Murray Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1947, at 7 A:M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1947 to Feb 3 1947 and that I last saw her alive on Feb 2 1947

Immediate cause of death Cerebral Hemorrhage DURATION 9 days

Due to General Arterio Sclerosis

Due to \_\_\_\_\_

Other conditions (none of note)

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Antopsy results \_\_\_\_\_ Date of op. \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Paul C. Van Vatter M. D. or other

Address Washington 19 DC Date signed Feb 3 1947

RECEIVED

FEB 8 1947

RECEIVED

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01944

2430

224

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Bowie  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 weeks  
Hospital, institution, or street address where death occurred  
High Bridge Road  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Bowie  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. High Bridge Road  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Marothy Virginia Parker

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
8. (b) Name of husband or wife Garfield Parker 8. (c) If alive, give age 36 years  
7. Birth date of deceased (mo., day, yr.) August 31, 1905  
8. AGE: Years 21 Months Days If less than one day  
.....hrs. ....min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1947 at ..... M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
.....19.....10.....19.....  
and that I last saw h.....alive on.....19.....

Immediate cause of death.....  
Toxemia  
Due to Pulmonary tuberculosis  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
.....Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

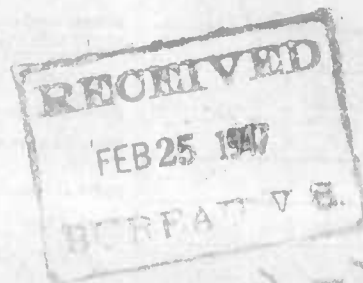
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
Reput Medical Exam  
23. SIGNATURE James T. G. G. G. M. D. or other  
Address Forestall Rd Date signed 2-17-47

9. Birthplace Elbert City, Md  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business Dom. House  
12. Name Marthy Virginia Parker  
13. Birthplace Baltimore, Md  
14. Maiden name Mary Gibson  
15. Birthplace Maryland  
16. Informant Mary Gibson  
Address Bowie, Md  
17. Burial Date thereof Feb. 20, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Brown Chapel  
Location Brown Chapel R.F.D.  
18. Funeral director Ridgely Selby  
Address 404 Wash Ave Laurel, Md  
19. Feb. 19, 47 Mrs. J.W. Giesinger  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 191-02

## CERTIFICATE OF DEATH

01945

Reg. Dist. No. 2310

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Glen Dale  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Glen Dale  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

John Thomas Parker

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Mary Parker  
7. Birth date of deceased (mo., day, yr.) Aug. 1869 8. (c) If alive, give age 73 years  
8. AGE: Years 77 Months Days It less than one day  
hrs. min.

9. Birthplace Howard County, Md  
(Town, county, and state)  
10. Usual occupation Retired  
11. Industry or business Laborer  
12. Name John Henry Parker  
13. Birthplace Md  
14. Maiden name Elysebeth Randall  
15. Birthplace Md

16. Informant Eugene O. Prother  
Address 1521-11th St NW, DC  
17. Removal Date thereof 2-19-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory  
Location Robert H. Smith  
18. Funeral director 1820-9th St. SW  
Address

19. 2/19 1947 Amanda Turner  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 19, 1947 at 10:30 A  
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from  
19..... to ..... 19.....  
and that I last saw him..... alive on ..... 19.....

Immediate cause of death.....  
Acute congestive heart failure  
Due to Cardiovascular renal disease  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

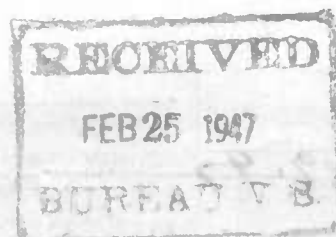
Major findings of operations..... Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Manner of injury Injured at work?  
Deputy medical examiner  
23. SIGNATURE Forester M. D. or other  
Address Forester Date signed 2-19-47

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

## CERTIFICATE OF DEATH

Reg. Dist. No. 01946 2468

1. PLACE OF DEATH: Prince George  
County.....  
City or town..... Hyattsville Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 35 years  
Hospital, institution, or street address where death occurred.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Prince Geo.  
City or town Hyattsville Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4809 Braxton Place  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Josephine Parron

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
8. (b) Name of husband or wife Tom Parron  
7. Birth date of deceased (mo., day, yr.) July 10 1900 6. (c) If alive, give age 43 years  
8. AGE: Years 46 Months 10 Days 10 hrs. min.

9. Birthplace Md.  
(Town, county, and state)  
10. Usual occupation House wife  
11. Industry or business  
FATHER 12. Name Thomas Sharps  
13. Birthplace Md.  
MOTHER 14. Maiden name Mary Plater  
15. Birthplace Md.

16. Informant Annie Sharps Hyattsville  
Address 4809 Braxton Place  
17. Burial Date thereof Feb 16, 1947  
(Burial, cremation, or removal, Which?)  
Cemetery or crematory Methodist Cemetery  
Location Bladensburg Md.  
18. Funeral director F. Gasch  
Address Hyattsville Md.  
19. Feb 15 1947 James Sevey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1947 at 3 P. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1947, to Feb 12 1947  
and that I last saw her alive on Feb 10 1947  
Immediate cause of death Cerebral Hemorrhage 20 days  
Due to High Blood pressure ?  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE W. S. Anderson  
Address 573 8th Street Md. Date signed 2-12-47

RECEIVED  
FEB 17 1947  
R-HEAD 18  
1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9140

# CERTIFICATE OF DEATH

Reg. Diat. No. 2310

01947

1. PLACE OF DEATH: Prince Georges  
County.....  
City or town..... Bladensburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 years  
Hospital, institution, or street address where death occurred:  
4219 Edmonston Road  
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Bladensburg  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4219 Edmonston Road  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

HARRY JOHNN PATTON

3. (b) Social Security Number  
217-05-2984

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife, Eva M.

6.(c) If alive, give age..... year

7. Birth date of deceased (mo., day, yr.) Sept 30, 1873

8. AGE:	Years	Months	Days	If less than one day
	73	4	8	..... hrs. .... min

9. Birthplace.....Hartford Co., Maryland  
(Town, county, and state)

Retired11. Industry or business .....

FATHER	12. Name.....	Henry Patton
	13. Birthplace.....	Md.

MOTHER 14. Maiden name.....Frances Gilbert.....  
15. Birthplace Md.

16. Informant..... Sedonia Harrigan  
Address..... 922 Perry Place, Wash., D.C.

17. Burial Date thereof. 2/10/47  
(Burial, cremation or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery  
Location Suitland, Maryland

18. Funeral director..... Wm. Rutherford Humphrey  
Address Bethesda, Maryland BK

19 2/10 19 47 Amanda Dourne  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....2-7.....1947 at 7 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1942 to Feb. 7, 1942 and that I last saw him alive on Feb. 6, 1942

Immediate cause of death.....  
*Acute Coronary Occlusion*.....

DURATION  
*1 week*

Due to.....

Due to.....

Other conditions.....

.....  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of on .....

**Autopsy results.**.....  
**PHYSICIAN:** Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

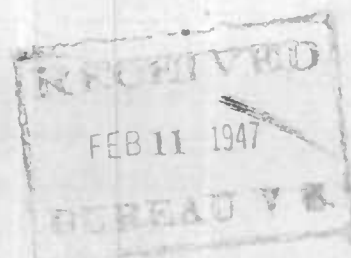
Where did injury occur? .....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury	Injured at work?
Car	Yes

23. SIGNATURE..... M. D. or other  
Address..... *Hattensale West* Date signed *2-8-47*





1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

01948

2450

## 1. PLACE OF DEATH:

County Prince George's County  
 City or town Riverdale Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Island Memorial HospitalHow long in hospital or institution? 1 hr.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince George's  
 City or town Landover Md.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 13V Hillside Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Robert Dean Peifer

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 19468. AGE: Years Months Days If less than one day  
9 8 10 hrs. min.9. Birthplace Riverdale Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name James Robert Peifer13. Birthplace Christiansburg, Illinois14. Maiden name Dorothy Marie15. Birthplace Secatur, Illinois16. Informant James PeiferAddress Greenbelt, Md.17. Shipping Date thereof 2/27/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Secatur, Del.18. Funeral director W. W. Chas. G.Address Riverdale, Md.19. Feb 27 47 James Gray  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26-47 19 47, at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 26 19 47 to Feb. 26 19 47and that I last saw him alive on Feb. 26 19 47Immediate cause of death Bilateral Broncho-  
Pneumonia

## DURATION

Due to

Due to

Other conditions

ANOXEMIADEHYDRATION

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Bronchopneumonia - Bilat. Dehydration

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Ernschan, M.D.Address 4404 Queensbury Rd. Riverdale, Md.Date signed 2-26-47

RECEIVED

FEB 28 1947

BUREAU V 8.

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-01

## CERTIFICATE OF DEATH

01949

Reg. Dist. No. 2421

### 1. PLACE OF DEATH:

County Prince George's  
City or town Ritchie  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Transient  
Hospital, institution, or street address where death occurred:  
White House Road  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Ritchie  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 7900 White House Road  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

William Henry Pinkney

### 3. (b) Social Security Number

4. Sex male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Jessie Pinkney  
6. (c) If alive, give age 18 years  
7. Birth date of deceased (mo., day, yr.) March 10, 1924

8. AGE: Years 22 Months 11 Days 4 It less than one day hrs. min.

9. Birthplace Ritchie, Md  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

12. Name James Pinkney

13. Birthplace Maryland

14. Maiden name Edith Harrison

15. Birthplace Maryland

16. Informant Edith Pinkney

Address Ritchie, Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Feb. 19, 1947  
(month) (day) (year)

Cemetery or crematory Paynes Cemetery

Location Washington DC

18. Funeral director E. G. Goch's Sons

Address Bladensburg Md

19. 2-18- 19 47 Thos S. English  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 19 47 at 12:57 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19

Immediate cause of death Thrombophlebitis and shock

Due to Crushed skull

Due to Crushed chest

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-16-47

Where did injury occur? Ritchie P. G. Md  
(City or town) (State)

Injured at home, farm, industry, public place (where) White House Road

Means of injury Driver's car that I was in

23. SIGNATURE James S. English M. D. or other

Address Forestville Md Date signed 2-16-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 26 1947

BUREAU V 8.

2-25

2-2420 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-2)

## CERTIFICATE OF DEATH

01950

Reg. Dist. No. 2390

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Fairfax  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? TransientHospital, institution, or street address where death occurred:  
Warrens HospitalHow long in hospital or institution?                     

## 3. (a) FULL NAME

Mildred Hazel Poe

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

May 26, 19416. (c) If alive, give age                      years

## 8. AGE:

Years 5 Months                      Days                       
 If less than one day                      hrs.                      min.

## 9. Birthplace

Sandy Spring, Md  
(Town, county, and state)

## 10. Usual occupation

none

## 11. Industry or business

12. Name Merle Edward Poe13. Birthplace Fairfax, Md14. Maiden name Branche d Welch15. Birthplace Seagoville, Md16. Informant Isidore P. WoodenAddress 1106 Snowden Place, Fairfax, Va17. Burial Date thereof Feb 16, 1947  
(Burial, exhumation, or removal, which) (month) (day) (year)Cemetery or crematory Immanuel CemeteryLocation Seagoville, Maryland18. Funeral director W. J. H. MarshallAddress Fairfax, Maryland19. Feb 15 19 47 M. Brashears  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Fairfax  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1106 Snowden Place  
(If rural, give LOCATION)2. (a) If veteran, name war                     

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1947 at 2:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from                      19                      to                      19                     and that I last saw him                      alive on                      19                     

## Immediate cause of death

Heart failureShockDue to fracture of right and secondcervical vertebra with compressionOf of chordOther condition fracture of right femur

(Include pregnancy within 3 months of death)

Major findings of operations                     Date of op.                     Autopsy results                     

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-13-47Where did injury occur? Seagoville, Maryland  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Route 216Means of injury Automobile struck by carReport made by Dr. J. H. Marshall23. SIGNATURE J. H. Marshall M. D. or other                     Address Seagoville, Md Date signed 2-13-47

RECEIVED

FEB 18 1947

BUREAU V.M.

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-2

01951

## CERTIFICATE OF DEATH

Reg. Dist. No.

2390

## 1. PLACE OF DEATH:

County Prince George  
 City or town Laurel  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 YRS.; 11 M.; 26 D  
 Hospital, institution, or street address where death occurred:  
Laurel Sanitarium, Laurel, Maryland  
 How long in hospital or institution? 4 YRS.; 11 M.; 26 D

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1323 Oak Hill Ave  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Alonso Miller Porter

## 3. (b) Social Security Number

Unk.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Divorced

6. (b) Name of husband or wife Bella Cantor7. Birth date of deceased (mo., day, yr.) June 24 - 1858

8. AGE: Years 88 Months 7 Days 30 If less than one day  
 hrs. min.

9. Birthplace Hagerstown, Maryland  
(Town, county, and state)10. Usual occupation Clinical pathologist11. Industry or business Major U. S. Army (retired)12. Name Alonso Miller Porter13. Birthplace Pennsylvania14. Maiden name Nancy Miller15. Birthplace Pennsylvania16. Informant Sanitarium RecordsAddress Laurel San., Laurel, Maryland17. Removal Date thereof Feb 23 - 1947  
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory St. Agostine Rd

Location

18. Funeral director C. M. Suter and SonsAddress Hagerstown, Md.19. Feb 23 1947 M. Beasly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1947 at 8:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1947 to Feb 23 1947  
 and that I last saw him alive on Feb 23 1947

Immediate cause of death

DURATION

Cardiac De compensation 3 weeksDue to Chronic Myocarditis unk. 7-9Due to General Arterio Sclerosis unkOther conditions Senility  
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John L. Welker, M.D.  
M. D. or otherAddress Laurel, Maryland Date signed 2/23/47

RECEIVED

FEB 26 1947

BUREAU 88

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

## CERTIFICATE OF DEATH

01952

Reg. Dist. No. 2451

## 1. PLACE OF DEATH:

County Prince George's  
 City or town College Park  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

University Lane and Ridge Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery CoCity or town Kensington Md  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 31 Nash street

(If rural, give LOCATION)

2.(c) If veteran, name war World War II

## 3. (a) FULL NAME

Walter Ernest Rawlings

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife --7. Birth date of deceased (mo., day, yr.) May 18, 1925

8. AGE: Years 21 Months 8 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington D. C.  
 (Town, county, and state)10. Usual occupation Surveyor  
National Geodetic Survey

11. Industry or business

12. Name James E. Rawlings13. Birthplace T. B. Maryland14. Maiden name Dorothy M Harris15. Birthplace Chicago Illinois16. Informant James E. RawlingsAddress Kensington Md17. removal Date thereof Feb 16, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Warner Pumphrey Funeral Home  
Silver Springs  
 Location Maryland

18. Funeral director F. Gasch's SonsAddress Hyattsville Maryland19. Feb 16 1947 Wm Jas. Gerner  
 (Date rec'd by registrar) (Signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1947 at 12:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19\_\_\_\_ to 19\_\_\_\_

and that I last saw h. \_\_\_\_\_ alive on 19\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION

Hemorrhage and shockDue to Compound comminuted fractureof both legs, mid portionDue to Crushed chestFracture base of skull

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-16-47Where did injury occur? College Park P. G (City or town) (County) (State)Injured at home, farm, industry, public place (where?) at place of deathMeans of injury Car that struck front (Induced at work)Neely's Medical Examiner23. SIGNATURE James E. Gerner M. D. or otherAddress Frederick Md Date signed 2-16-47

RECEIVED  
FEB 17 1947  
RECEIVED  
1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49-2

## CERTIFICATE OF DEATH

01953

Reg. Dist. No. 2310

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Prince Georges General Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Pr. Ges.  
City or town Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4108 Rainier Ave.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Reier, Mrs. Laura

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Reier, Mr. George  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) April 17 - 1877  
8. AGE: Years 69 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace md.  
(Town, county, and state)  
10. Usual occupation H. W.  
11. Industry or business  
FATHER  
12. Name John Baublitz  
13. Birthplace Pa.  
MOTHER  
14. Maiden name Mary Catherine Matthias  
15. Birthplace Pa.

16. Informant Mr. Edmund Reier  
Address 4108 Rainier Ave Mt. Rainier  
17. Burial Date thereof 2/20/1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory St. Lincoln  
Location Wash. - Balto Blvd + D. C. Line Md.  
18. Funeral director Wm. J. Mallory  
Address 3200 St. J. Ave. Mt. Rainier Md.  
19. 2/20 47 Amanda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17 19 47 at 11 30 M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 45 to Feb. 17 19 47  
and that I last saw him alive on Feb. 17 19 47

Immediate cause of death Toxemia  
DURATION 3 weeks  
Due to Squamous cell carcinoma of the cervix with direct extension to the cervix, uterus and adjacent tissue 17 months  
Due to

Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

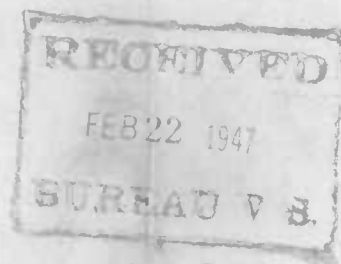
23. SIGNATURE Floyd W. Hughes M.D.  
M. D. or other  
Address Prince Georges General Hospital signed 2-18-47

MARGIN RESERVED FOR BINDING

9.45:15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1 - 35

## CERTIFICATE OF DEATH

COMMONWEALTH OF MARYLAND  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

## 1. PLACE OF DEATH

County of PRINCE GEORGERegistration District No. 240

Township of \_\_\_\_\_

or  
Borough of  
or

Primary Registration District No. \_\_\_\_\_

City of CEDARVILLE(No. BRANDYWINE ROUTE #1)

Registered No. \_\_\_\_\_

[If death occurred in a  
Hospital or Institution  
give its NAME instead  
of street and number.]2. FULL NAME NORVEL' ERICHARDS

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

M

## 4. COLOR OR RACE

W5. SINGLE, MARRIED, WIDOWED  
OR DIVORCED (write the word)MARRIED -5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofLEE DAVIS RICHARDS

## 6. DATE OF BIRTH (month, day, and year)

Jan. 9, 1882

## 7. AGE

Years

Months

Days

IF LESS than  
1 day.....hrs.  
or.....min.6522

## 8. OCCUPATION OF DECEASED

- (a) Trade, profession, or
- 
- particular kind of work.
- 
- (b) General nature of industry,
- 
- business, or establishment in
- 
- which employed (or employer)
- 
- (c) Name of employer

FARMER -

## 9. BIRTHPLACE (city or town)

(State or country)

PRINCE GEORGE, MD.

## 10. NAME OF FATHER

MARCELLUS RICHARDS

## 11. BIRTHPLACE OF FATHER (city or town)

(State or country)

PRINCE GEORGE'S, MD.

## 12. NAME OF MOTHER

BELLA GIBBONS

## 13. BIRTHPLACE OF MOTHER (city or town)

(State or country)

PRINCE GEORGE'S, MD.

## 14.

Informant

GUY REUBEN SEGER

(Address)

BRANDYWINE ROUTE #1, MD.

## 15.

Filed

Feb 1, 1947F. H. Billingsley

REGISTRAR

11-3184

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

FEBRUARY 11947

(Month)

(Day)

(Year)

## 17.

I HEREBY CERTIFY, That I attended deceased from,

JAN 281947FEB 11947that I last saw him alive on JAN 311947and that death occurred, on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH\* was as follows:

CARDIAC FAILURE DUE TO  
ANTERIOR CORONARY  
HEART DISEASE(duration) 3 yrs. + + mos. + + ds.CONTRIBUTORY  
(SECONDARY)PASSIVE CONGESTION(duration) 3 yrs. + + mos. + + ds.

## 18. Where was disease contracted

If not at place of death?

NOT CONTRACTED

Did an operation precede death?

NO

Date of \_\_\_\_\_

Was there an autopsy?

NO

What test confirmed diagnosis?

(Signed)

Alfred R. Laper

M. D.

Feb 11947

(Address)

Aguasco, Md.\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state  
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or  
HOMICIDAL. (See reverse side for additional space.)19. PLACE OF BURIAL, CREMATION OR  
REMOVAL

## DATE OF BURIAL

Cedarville CemeteryFeb 31947

## 20. UNDERTAKER

## ADDRESS

Ritchie Bros.Upper Marlboro  
Md.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state EXACTLY CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.

Every item of information should be carefully supplied. AGE should be stated EXACTLY.



A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (h) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer, Farm laborer, Laborer—Coal mine etc.* Women at home who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever write *None*.

**Statement of cause of death.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term of

the same diseases. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup") *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., carcinoma, Sarcoma, etc., of . . . . .* (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitia Inephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example. *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicaemia" "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—Probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

Space for additional information by physician

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181-B

## CERTIFICATE OF DEATH

01955  
Reg. Dist. No. 2310

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Cheverly Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 years  
 Hospital, institution, or street address where death occurred  
Prince Georges Gen Hospital  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Mt. Rainier  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3803 - 350 St. Mt Rainier  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

Richardson, Eva M

## 3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife George  
 6. (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 30, 1888  
 8. AGE: Years 58 1/2 Months 4 Days 12 It less than one day hrs. min.

9. Birthplace Connecticut  
 (Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name Reverend  
 13. Birthplace Conn.

14. Maiden name Wicks  
 15. Birthplace

16. Informant Husband - George  
 Address SAME

17. Burial Date thereof 2/20/1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory F.D. Lincoln  
 Location Wash - Balto Blvd + D.C. Line Md.

18. Funeral director Wm J. Valley  
 Address 3200 - R.I. Ave. Mt. Rainier Md.

19. 2/20 19 47 Amadeo D. Denny  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 18 February 1947 at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/15 19 47 to 2-18-47 19 47 and that I last saw h. ex. alive on 2/18 11:5A 19 47

Immediate cause of death Chronic glomerular - nephritis

Due to

Due to

Congenital Malformation of feet - paralytic  
 Other conditions Chronic glomerular - nephritis  
Pulmonary - Cardiac hypertrophy - Atherosclerosis  
Arteriosclerosis - Diabetes - Hypertension  
 (Include pregnancy within 3 months of death)

Major findings of operations 2/18/47

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Flayd W. Hughes M.D.  
 Address Prince Georges General Hosp Date signed 2-18-47

RECEIVED

FEB 22 1947

BUREAU V S

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01956

Reg. Dist. No. 2310

### 1. PLACE OF DEATH:

County Prince George  
City or town Chenoweth  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 14 hrs. 25 min.  
Hospital, institution, or street address where death occurred:  
Prince George Hospital  
How long in hospital or institution? 14 hrs. 25 min.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State District of Columbia  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2949 Mills Ave. N.E. D.C.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Ross, Mr. Oliver G.

### 3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) single, married, widowed, divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1867 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 79 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Painter (Sign)

### 11. Industry or business

12. Name Charles Ross

13. Birthplace VA

14. Maiden name Lucretia Corn

15. Birthplace VA

16. Informant Fannie Ross

Address 2949 Mills Ave. N.E. Wash. D.C.

17. Removal Date thereof Feb. 13, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location \_\_\_\_\_

18. Funeral director James T. Ryan, Inc.

Address 1317 PA Ave. S.E.

19. 2/13 19 47 Amanda Dourney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 19 47 at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9th 19 32 to Feb. 13th 19 47

and that I last saw him alive on February 13th 19 47

Immediate cause of death Prerenia with shock

Due to Chronic Degeneration

Due to Nephritis

Due to Aortic Stenosis with Regurgitation

Other conditions Secondary anemia with debilitation  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Antopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles E. Brown

Address 2001 R Ave. N.E. Wash. D.C.

Date signed 2-13-47

MARGIN RESERVED FOR BINDING

I

4

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 15 1947

BUREAU V A

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (694)

## CERTIFICATE OF DEATH

Reg. Dist. No.

01957

2481

## 1. PLACE OF DEATH:

County PRINCE GEORGE  
 City or town HRATTVILLE  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 YEARS  
 Hospital, institution, or street address where death occurred:  
5805 Queen's Chapel Road.  
 How long in hospital or institution? 2 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County \_\_\_\_\_  
 City or town BALTIMORE  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 818- E-22nd Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

WINIFRED ROSS

## 3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOW

6. (b) Name of husband or wife

LOUIS W. ROSS

7. Birth date of deceased (mo., day, yr.)

APR. 7, 1867

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

79

10

20

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

MOTHER FATHER

12. Name

LENN CARNEY

13. Birthplace

IRELAND

14. Maiden name

CATHERINE KILDUFF

15. Birthplace

MARYLAND

16. Informant

SACRED HEART HOME RECORD

Address

5805-Queen's Chapel Rd. Mattaville, Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Mt. Olivet Cemetery

Location

Washington, D.C.

18. Funeral director

Francis Hollins

Address

3821-14th St. N.W. Wash. D.C.

19.

(Date rec'd by registrar)

Feb. 27, 1947 Mrs. Jas. Severe Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1947 7:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 4 1947 to February 27 1947

and that I last saw him alive on February 26 1947

Immediate cause of death

Congestive heart failure  
Hyperthyroid basis

DURATION

2 wks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

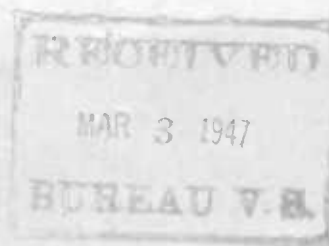
23. SIGNATURE

James Hallin

M. D. or other

Address 322 H Street NE

Date signed 2-27-47



1-25-

2-2450 — 1-10



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

01958

Reg. Dist. No. 2310

## 1. PLACE OF DEATH:

County Pr. Geo. Co  
 City or town Columbia Manor - Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pr. Geo. Co  
 City or town Alexandria  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rt 1 Box 40 W.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

George Leonard Schlark

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Mary Ellen Schlark

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 4 - 18638. AGE: Years 83 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation Retired Farmer

## 11. Industry or business

12. Name Wm Schlark13. Birthplace Germany14. Maiden name Mary Kellian15. Birthplace Germany16. Informant Wm SchlarkAddress R.F.D. Box 40 Alexandria Va17. Date thereof Feb-11-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill CemeteryLocation Southland, Md18. Funeral director Wm Charles GAddress 577-11 St P.E.19. 2/9 1947 Annie Dancy

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1947 at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to 2-8 1947  
and that I last saw him alive on 2-7 1947Immediate cause of death Coronary thrombosis DURATION  suddenDue to Arterio sclerosis 1946

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Jim am / dancy M. D. or otherAddress Synott - Md Date signed 2-8-47

RECEIVED

FEB 11 1947

SHREVEPORT, LA.

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01959

Reg. Dist. No. 2420

### 1. PLACE OF DEATH:

County Prince Georges

City or town Capital Heights

How long in above place of death? 6 mo

Hospital, institution, or street address where death occurred:

328-48th St ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Capital Heights

Street No. 328-48th

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

Richard O'dell Seay

### 3.(b) Social Security Number

#### 4. Sex

male

#### 5. Color or race

white

#### 6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife Phyllis Seay

7. Birth date of deceased (mo., day, yr.) December 7, 1910

6.(c) If alive, give age 25 years

8. AGE: Years 36 Months - Days - It less than one day hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Electrician

11. Industry or business

12. Name Seay

13. Birthplace Virginia

14. Maiden name Naomi Waller

15. Birthplace Virginia

16. Informant Phyllis Seay

Address 328-48th Ave., Capital Heights

17. (Burial, cremation, or removal, etc.) Date thereof Feb 22, 1947

Cemetery or crematory Potomac

Location Washington D.C.

18. Funeral director St. O. Chambers Co

Address 577-11th St SE

19. Feb 22, 1947 Carrie F. Campbell

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1947, at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

acute congestive heart failure

Due to Chronic alcoholism

Due to

Other conditions Cirrhosis of the liver

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of Injury

23. SIGNATURE Deputy medical examiner

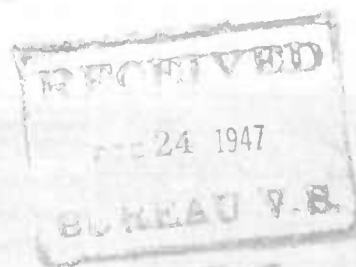
Address Frostburg, Md

Date signed 2-21-47

MARGIN RESERVED FOR BINDING

VS A15 9-15-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

## CERTIFICATE OF DEATH

01960

Reg. Dist. No. 2320

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Rural - Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State 2nd County P. GeoCity or town Rural - Upper Marlboro Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2 1/2 east - Highway 2  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Douglas Sellman

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

C

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec 17, 1946

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

211

hrs.

min.

9. Birthplace Upper Marlboro P. Geo, Maryland  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Wilson Sellman

13. Birthplace

P. Geo Co

MOTHER

14. Maiden name

Gladys Bruce

15. Birthplace

P. Geo Co

16. Informant

Gladys Sellman

Address

Upper Marlboro, Md

17.

BurialDate thereof 3-1-47  
(month) (day) (year)

Cemetery or crematory

St. Carmine

Location

Upper Marlboro, Md.

18. Funeral director

Relief Bros.

Address

Upper Marlboro, Md.

19.

March 1, 1947

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Feb 19 47 at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

26 Feb 19 47 to 28 Feb 19 47and that I last saw him alive on 28 Feb 19 47Immediate cause of death Pneumonia

DURATION

2 dayDue to Gyphingia3 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert B. Sauer

M. D. or other

Address Upper Marlboro, Md Date signed 28 Feb 47

CERTIFICATE OF DEATH

RECORDED  
MAY 3 1947  
BUREAU OF VITALS

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *mt51*

## 1. PLACE OF DEATH:

County *PRINCE GEORGE*City or town *HYATTSVILLE*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *1 yr. 1 mo. 23 days*

Hospital, institution, or street address where death occurred:

*SACRED HEART HOME*How long in hospital or institution? *8 yrs. 1 mo. 23 days*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *D. C.* CountyCity or town *WASHINGTON*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *1308-16TH ST. N.W.*  
(If rural, give LOCATION)2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

*MARY P. SMART*

## 3. (b) Social Security Number

4. Sex

*FEMALE*

5. Color or race

*WHITE*

6. (a) Single, married, widowed, or divorced

*SINGLE*

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *DEC. 15, 1873*

8. AGE:

Years

*73*

Months

*2*

Days

*8*

If less than one day

*hrs.**min.*

9. Birthplace

*WYOMING*

(Town, county, and state)

10. Usual occupation

*NONE*

11. Industry or business

MOTHER FATHER

12. Name

*CHARLES SMART*

13. Birthplace

*SCOTLAND*

14. Maternal name

*DORA PURCELL*

15. Birthplace

*IRELAND*

16. Informant

*SACRED HEART HOME RECORDS*Address *5805 Queen's Chapel Rd. Hyattsville Md*

17. Burial

*Burial* Date thereof *2-25-47*  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory

*St. Vincent Cemetery*

Location

*Washington, D.C.*

18. Funeral director

*Francis Collins*

Address

*3821-14th St. N.W. Wash. D.C.*

19. Filed

*Feb. 23, 1947*

(Date rec'd by registrar)

*Miss Joe Jensen*  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 23* 19 *47* at *12:30* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jan 1* 19 *47* to *Feb 23* 19 *47*  
and that I last saw him alive on *Feb 22* 19 *47*

Immediate cause of death

*Congestive heart failure*  
*Myocardial infarction*

DURATION

*3 weeks*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Francis Collins M.D.*

M. D. or other

Address

*3821-14th St. N.W. Wash. D.C.* Date signed *Feb 23-47*





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

01962

2310

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

Prince Georges HospitalHow long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town College Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4607 Norwich Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Harry Stello

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Annetta Stello

## 7. Birth date of

deceased (mo., day, yr.)

June 26 - 1894

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

52

Months

7

Days

25

If less than one day

hrs.

min.

## 9. Birthplace

Washington D.C.  
(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

## FATHER

## 12. Name

Henry Stello

## 13. Birthplace

Wash. D.C.

## MOTHER

## 14. Maiden name

Annie M. Donald

## 15. Birthplace

Wash. D.C.

## 16. Informant

Son - Harry Stello, Jr.

## Address

4607 Norwich Rd., College Park

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Feb 24, 1947  
(month) (day) (year)

## Cemetery or crematory

Fort Lincoln

## Location

Washington D.C.

## 18. Funeral director

F. Pasche sons

## Address

2/23 47 Amanda Downey

## 19. (Date read by registrar)

2/23 47

## 19. (Date read by registrar)

Amanda Downey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21, 1947 19 30 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 FEB19

to

21 FEB1947

and that I last saw him alive on

20 FEB1947

Immediate cause of death

Acute CARDIAC  
DILATION & FAILURE  
secondary to Chronic

DURATION

Due to

Myocarditis  
Acute Fatty Infiltration  
of the Liver

Due to

Other conditions

OBESITY

(Include pregnancy within 8 months of death)

Major findings of operations

NONE

Date of op.

Autopsy results

AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Etienne M.D.

M. D. or other

Address

Berwyn, Ind

Date signed

2/22/47

RECEIVED

FEB 25 1947

BUREAU V B.

1-36

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

## CERTIFICATE OF DEATH

Reg. Dist. No. 1420

## 1. PLACE OF DEATH:

County Prince George'sCity or town Adelphi  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 36 years

Hospital, institution, or street address where death occurred:

6700 Walker Hill Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Adelphi  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6700 Walker Hill Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Wilhelm Henry Stock

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Julia Stock6. (c) If alive, give age 63 years

## 7. Birth date of

deceased (mo., day, yr.)

March 17, 1873

## 8. AGE:

Years

73

Months

10

Days

4

If less than one day

.....hrs. ....min.

## 9. Birthplace

Germany  
(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

## FATHER

## MOTHER

## 12. Name

Wilhelm Stock

## 13. Birthplace

Germany

## 14. Maiden name

Wilhelmine Wash

## 15. Birthplace

Germany

## 16. Informant

Elsie Volk

## Address

6700 Walker Hill Road

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb 20, 1947  
(month) (day) (year)

## Cemetery or crematory

Forestville Cemetery

## Location

Forestville Md

## 18. Funeral director

F. Pasch's sons

## Address

Hyattsville Md

## 19. 2/23

(Date rec'd by registrar)

1947

Amanda Doney  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1947, at 5:24 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Death congestive heart failure

Due to

Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? .....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

James J. Doney  
M. D. or otherAddress Forestville Md Date signed 2-21-47

CERTIFICATE OF DEATH

ALL DEATHS MUST BE REPORTED TO THE DEPARTMENT OF HEALTH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

RECEIVED

MAR 3 1947

BUREAU & B.

2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Bla

## CERTIFICATE OF DEATH

Reg. Dist. No. 01964 2320

## 1. PLACE OF DEATH

County Prince Georges  
 City or town Rossaryville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town Rossaryville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Alfred J. Taylor

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) March 30, 1878 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 68 Months 10 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Paterson N. J.  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Unknown13. Birthplace England14. Maiden name Unknown15. Birthplace England16. Informant Mrs. Code J. OliverAddress Cheftentham17. Burial Date thereof 2-24-47

(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory CheltenhamLocation Cheltenham18. Funeral director Peter BrothersAddress Upper Marlboro19. Feb 27 47 19 47

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1947 at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1, 1947 to Feb 23, 1947  
 and that I last saw him alive on Feb 23, 1947

Immediate cause of death Cerebral thrombosis  
Cardiovascular disease

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James T. Bond  
 M. D. or other \_\_\_\_\_

Address Quesholt Date signed 2-26-47

10010

RECEIVED

ARTS & CRAFTS

RECEIVED

RECEIVED

RECEIVED  
FEB 28 1947  
BY READ V B.

1-35



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

01965

## CERTIFICATE OF DEATH

Reg. Dist. No. 2370

## 1. PLACE OF DEATH:

County... Prince Georges

City or town... Brandywine  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince Georges

City or town... Brandywine  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Joseph Richard Thomas Jr

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Caucasian

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.) September 29, 1946

## 8. AGE:

Years

Months

Days

If less than one day

4

9

hrs.

min.

## 9. Birthplace

Brandywine Md  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name Joseph Richard Thomas Jr

## 13. Birthplace

Maryland

## 14. Maiden name

Joseph Henrietta Harper

## 15. Birthplace

Maryland

## 18. Informant

J. R. Thomas Sr

## Address

Brandywine Md

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2-8-47  
(month) (day) (year)

## Cemetery or crematory

House of God Cemetery

## Location

Brandywine Md

## 18. Funeral director

Smith &amp; Gay

## Address

Waldorf Md

## 19. Feb 11th

(Date rec'd by registrar)

19

47

Mrs H. B. Contee

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH February 7 1947 at 7:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

## Immediate cause of death

Asphyxia

## DURATION

Due to Overlapping 2 months

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Underliest Date of 2-7-47

Where did injury occur? Brandywine P. G. Md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Overlapping 2 months Injured at work? No

Nelegit medical Examine

23. SIGNATURE James J. Sofa M. D. or other

Address Forestallin Date signed 2-7-47

MARGIN RESERVED FOR BINDING

VS A15

9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 13 1947

BUREAU V. B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 797

## CERTIFICATE OF DEATH

01966

Reg. Dist. No. 2450

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Riversdale Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 55 days

Hospital, institution, or street address where death occurred:

Seland Memorial HospitalHow long in hospital or institution? 55 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_

City or town Washington D.C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1312 Longfellow Street N.W.  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs Lodema Travis

## 3. (b) Social Security Number

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, married, widowed, or divorced \_\_\_\_\_

Female White Widowed6. (b) Name of husband or wife Thomas J. Travis

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 11, 1889

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Delta Co, Ohio  
(Town, county, and state)10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Levi Alwood13. Birthplace ?, Ohio14. Maiden name Delilah McQuillan15. Birthplace ?, Ohio16. Informant Stanley E. TravisAddress 1380 Fort Stevens Drive N.W.17. Burial Wash. D.C.  
(Burial, cremation, or removal. Which?) Date thereof Feb 4 1947  
(month) (day) (year)Cemetery or crematory Greenwood CemeteryLocation Washington D.C.18. Funeral director S. H. Jones Co.Address 2901-14th ST. N.W.19. Feb 2 1947 James Sevey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1947 at 2:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8, 1946 to February 1, 1947  
and that I last saw him/her alive on February 1, 1947Immediate cause of death Heart Disease DURATION 1 yr.Due to Atherosclerosis, Generalized 30 yrs.

Due to \_\_\_\_\_

Other conditions Decubitus Ulcers of Left Heel & Back 1 mo.  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

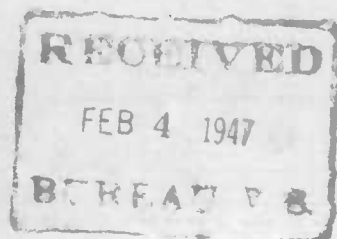
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walbert W. Gibson, M.D. M. D. or other \_\_\_\_\_Address Riversdale, Md. Date signed 2-1-47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01967 2450

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County PRINCE GEORGE  
 City or town TAKOMA PARK  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7302 HILTON AVE.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

MRS. EDITH WALL TWEEDALE

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M.  
 6. (b) Name of husband or wife ALONZO  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) DEC. 23-1870  
 8. AGE: Years 76 Months 2 Days 3 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace ENGLAND  
 (Town, county, and state)  
 10. Usual occupation RETIRED  
 11. Industry or business  
 12. Name ANDREW WALL  
 13. Birthplace ENGLAND  
 14. Maiden name AGNES BENT  
 15. Birthplace ENGLAND

16. Informant MR. ALONZO TWEEDALE  
 Address 7302 HILTON AVE. TAKOMA PARK  
 17. (Burial, cremation, or removal. Which?) BURIAL Date thereof 3-28-47  
 (month) (day) (year)  
 Cemetery or crematory GLENWOOD  
 Location WASHINGTON, DC  
 18. Funeral director Joseph J. Lawler, Son  
 Address 756 PENN. AVE. N.W. WASH. DC.  
 19. Feb 28 1947 James Severy  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1947 10:45 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 1905 to date of death  
 and that I last saw her alive on February 24 1947  
 Immediate cause of death Coronary Thrombosis DURATION  
10 yrs  
 Due to Organic Heart Disease 10 yrs  
 Due to Arterio Sclerosis 30 yrs  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE M. A. English M.D. M. D. or other  
 Address 1026 16th St. N.W. Date signed 2/25/47

RECEIVED

MAR 3 1947

BUREAU V.R.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 117-2

## CERTIFICATE OF DEATH

01968

Reg. Dist. No. 2451

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Riverdale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 Years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George's  
 City or town University Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4405 Underwood Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

EDWARD MINOR WALKER

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Dorothy Walker

7. Birth date of deceased (mo., day, yr.) April 21, 1905 6.(c) If alive, give age..... years

8. AGE: Years 41 Months Days If less than one day  
 hrs. min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation Salesman

11. Industry or business  
 12. Name John B. Walker

13. Birthplace Bedford, Co., Virginia

14. Maiden name Ellic Price Carter

15. Birthplace Virginia

16. Informant Mr. F. Carrol Howard

Address 4401 Underwood St., University

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Feb. 5, 1947  
 (month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location Washington, D. C.

18. Funeral director W. W. CHAMBERS CO.

Address Riverdale, Maryland.

19. Feb. 3, 1947 (Date rec'd by registrar) Mo. for Severed Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1947, 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19....., to 19.....  
 and that I last saw him..... alive on 19.....

Immediate cause of death Hemorrhage and shock DURATION

Due to Gastric Ulcers

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

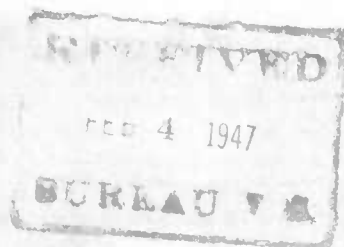
Injured at home, farm, industry, public place (where?).....

Means of injury Injured at work? Reput. Medical Examiner

23. SIGNATURE James J. Zest D. or other

Address Forestville Md. Date signed 2-2-47





1-25

2-2450- 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9370)

## CERTIFICATE OF DEATH

Reg. Dist. No.

01969

2340

## 1. PLACE OF DEATH:

County Prince Geo  
 City or town Chapel Hill md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Prince Geo  
 City or town Chapel Hill md  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
 (If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Charles Harries Jr  
 4. Sex M 5. Color or race Cu 6.(a) Single, married, widowed, or divorced Single

## 3. (b) Social Security Number

6.(b) Name of husband or wife .....

6.(c) If alive, give age .....

7. Birth date of deceased (mo., day, yr.) Sept 17 - 1870

8. AGE: Years 76 Months 5 Days 1 It less than one day  
 hrs. .... min.

9. Birthplace Prince Geo Co md  
 (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

12. Name Charles Harries Jr  
 13. Birthplace Prince Geo Co md

MOTHER  
 14. Maiden name Eliza  
 15. Birthplace Prince Geo Co md

16. Informant Catherine Cashert  
 Address Chapel Hill md

17. Burial Date thereof 2-22-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chapel Hill Cemetery  
 Location Chapel Hill md

18. Funeral director Wm. H. & Ryon  
 Address Wm. H. & Ryon

19. Feb 20 1947 Mr. Alton Davis  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 19 1947 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 18 1947 to Feb 18 1947and that I last saw him alive on Feb 18 1947Immediate cause of death Chronic myocarditis DURATION IndefiniteageDue to age

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE John E. Bowers MD M. D. or otherAddress Brandywine Pa Date signed 2/19/47

RECEIVED

FEB 22 1947

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1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01970

2310

## 1. PLACE OF DEATH:

County Prince George

City or town Cheverley

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Georges Gen Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo. County

City or town Brandywine

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Watson - Baykin

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ethel Edlund

6. (c) If alive, give age

63

7. Birth date of

deceased (mo., day, yr.)

11-10-1874

8. AGE:

Years

Months

Days

If less than one day

72

3

14

hrs.

min.

9. Birthplace

Pr. Geo. County - Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Eli J. Watson

13. Birthplace

Md.

MOTHER

14. Maiden name

Mary Freeman

15. Birthplace

Md.

16. Informant

Stacey B. Watson

Address

3900 - Hamilton - Hyattsville

17.

(Burial, cremation, or removal, which?)

Date thereof

2/22/47

Cemetery or crematory

St. Pauls

Location

Baden, Md.

18. Funeral director

Huntt &amp; Ryon

Address

Waldorf, Md.

19.

(Date rec'd by registrar)

19.

47

Amanda Dorey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

2-24-47

19.

at 2:07 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-13

19.

42 to 2-24

19.

and that I last saw him

alive on

2-23-47

19.

Immediate cause of death

Carcinoma of Head of Pancreas

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma of Head of Pancreas Metastasis to Liver

Autopsy results

to Liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Albert W. H.

M. D. or other

Address

Hattsville, Md.

Date signed 2-24-47

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FEB 26 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 2450

## 1. PLACE OF DEATH

County Pro Geo Co  
 City or town Hyattsville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 hours  
 Hospital, institution or street address where death occurred:  
Mother Jones Rest Home  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Pro Geo Co  
 City or town Hyattsville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4206 Slocator st  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Louise E. Wotmer

## 3. (b) Social Security Number

4. Sex Female; 5. Color or race white; 6.(a) Single, married, widowed, or divorced single;  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Jan 27, 1861  
 8. AGE: Years 86 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace New York  
 (State, county, and state)  
 10. Usual occupation retired school teacher  
 11. Industry or business

MOTHER FATHER  
 12. Name Martin Wotmer  
 13. Birthplace N.Y.  
 14. Maiden name Elizabeth King  
 15. Birthplace N.Y.

16. Informant Alice Wotmer Rice  
 Address Hyattsville Md.  
 17. Cremation Date thereof Jan 10, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill  
 Location Suitland Md  
 18. Funeral director F Pascha sons  
 Address Hyattsville Md

19. Jan 9 1947 James Sevey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7, 1947 at 7:00 PM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-5 1947, to 2-7 1947  
 and that I last saw him alive on 2-6 1947  
 Immediate cause of death \_\_\_\_\_

myocarditis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE James Sevey M. D. James Sevey  
Hyattsville Md Date signed Feb 7, 1947

RECEIVED

FEB 10 1947

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01972

Reg. Dist. No. *4250*

### 1. PLACE OF DEATH:

County *Pro Geo Co*

City or town *University Park Md.*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *12 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Pro Geo Co:*

City or town *University Park Md.*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. *4209 Sheridan Ave.*  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

*Charles Benjamin Woodward*

### 3. (b) Social Security Number

4. Sex

*male*

5. Color or race

*white*

6.(a) Single, married, widowed, or divorced

*widowed*

6.(b) Name of husband or wife

*Carrie E. Woodward*

7. Birth date of deceased (mo., day, yr.)

*July 12, 1865*

8. AGE:

Years *81*

Months

Days

If less than one day

hrs.

min.

9. Birthplace

*New York*

10. Usual occupation

*Retired tariff examiner*

11. Industry or business

*abel woodward*

12. Name

*New York*

13. Birthplace

*Ethel Collins*

14. Maiden name

*New York*

15. Birthplace

*Mrs Marie Turner*

16. Informant

*University Park Md.*

Address

*Burial Jan 17, 1947*

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

*Fort Lincoln*

Location

*Washington D.C.*

18. Funeral director

*A. Stasche sons*

Address

*Hyattsville Md*

19. (Date rec'd by registrar)

*Jan 15 1947 James Sever*

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 14* 19*47* at *11:30* A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*May 1900* 19*19* to *Feb 14* 19*47*

and that I last saw him alive on *Feb 14* 19*47*

Immediate cause of death

*Cancerous gall bladder*

DURATION

*6 mo*

Due to

Due to

Other conditions *Diabetes glomerula*

*hypocarcinoma*  
(Include pregnancy within 3 months of death)

*2 yrs*

*6 mo*

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

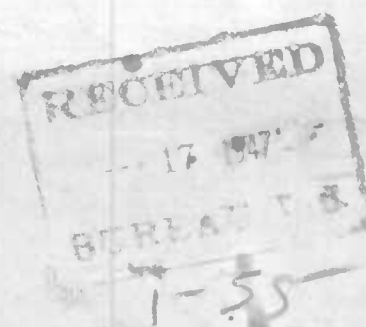
*John K. Hahn* M. D. or other

Address *4108 N. Charles St.* Date signed *2/14/47*

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01973

Reg. Dist. No. 2431

## 1. PLACE OF DEATH:

County..... Prince Georges  
 City or town..... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 months, 10 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 7 months, 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2503 M. St. N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

PHILANDER YOUNG Jr

## 3. (b) Social Security Number

577-16-8731

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife..... Nokomis Glenn Young

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1904

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
 43 43 1 4 ..... hrs. .... min.

9. Birthplace..... Clinton, South Carolina  
(Town, county, and state)

10. Usual occupation..... Auto Mechanic

## 11. Industry or business

12. Name..... Philander Young

13. Birthplace..... Clinton, South Carolina

14. Maiden name..... Ida Copeland

15. Birthplace..... Clinton, South Carolina

16. Informant..... Deceased

Address

17. removal Date thereof Feb. 27, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Washington, D.C.

18. Funeral director..... Joseph A. Janice

Address 1241 - 22nd St., N.W., Washington, D.C.

19. Feb. 27, 1947 Rowlands S. Philips  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1947, at 8:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15, 1946 to Feb 26, 1947  
 and that I last saw him alive on Feb 26, 1947

Immediate cause of death

Pulmonary Tuberculosis

DURATION

17 MOS

Due to

Tuberculosis of spine

17 MOS

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

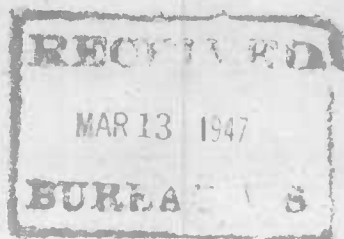
Injured at work?

23. SIGNATURE

Daniel Leo Pinucane M.D.

M. D. or other

Address Glenn Dale, Md. Date signed 2/26/47



2-25

2-2430 - 2-10